5-02410							Black Indel						
arnett, Kenneth		Sta	ate of	Maryland	/ Depai	rtment of	Health and	Mental H	lygiene				
		l-For State Registrar			Cert	rificate of	Death			Reg. No.	20	116	-1150
Physicia		1. Decedent's Name (First, Middle	e,Last)						2. Date of D		Print Colo	3.	Time of Death
ledical Examir	-	Kenneth Stev	en B	arnett					Month April 8,	2006	Year		13:39
		4a. Facility Name (if not institution			.)	14	lb. City, Town, or L	ocation of Death			. County of	Death	
)	н	1087 Ocean Parkway					Ocean Pines	8		V	Vorceste	er	
Funeral	-		6. Sex	7 A	ge (In yrs. las	st birthday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of	Birth (MM/	DD/YYYY)	9 Birthol	ace (State or Foreig
Director		218-82-7395			43		Months Days		n.			Countr	y)
Silicotol			1 X M	2F	43	Yrs			Oct.	29,	1962	Wash	ington, D
ž.		Usual Residence of Decedent 10a. State 10b. County			100 City T	Fown or Locati	00					10	d. Inside City Limits
w any		Toa. State Tob. County			Toc. City, 1	TOWITOT LOCAL	OII					10	Yes 2 No
faryland 28a-f show I at once,	ö	Maryland Worce	ster		0cea	an Pine	s						res 2 A No
Aaryl 28a-	Director	10e. Street and Number					10f. Zip Code			10g. Citi	zen of Wha	at Country	?
r death with the Maryland or items 23a or 28a-f sho must be notified at once,	ᡖ	1087 Ocean Park	wav				218	11		T	nited	Sta	tes
with s 23	ह	11. Marital Status		Was Deceder	t Ever in U.S	i. 13. Wa	s Decedent of Hisp		pecify Yes or				Indian, Black,
eath item	Funeral	1 Never Married 2 Ma	rried	Armed Forces		If Y	es, specify Cuban,	Mexican, Puerto	Rican, etc.)		White,	etc.	
ter d		3 Widowed 4 X X Dive	orced If Ye	Yes 2 es, Give Year	≥ A No	1	Yes 2 No	specify:			Specify:	White	e
hours after "natural", Examiner	<u>\$</u>	15. Decedent's Education (Spec	or E	Dates:	mpleted)		t's Usual Occupation		work done	16b. l	Cind of Bus	iness/Indu	istrv
hou "nat	Completed	Elementary/Secondary (0-12)		College (1-4 or		during							,
36 iin 7, han dical	음			3. year			vorking life. DO NO	of use retired)			D		•
with With her t	E	12 years: 17. Father's Name (First, Middle,	1 oct)	J. year	5	Annou		8.Mother's Name	o /Eiret Middl		Broad	icast:	ing
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica							1,						
12 d be fenta larke		Nelson Ford Bar		D-i-4.)		401 14-11	1	Rebecca				04-4- 7:	- Codo)
Shoul nd N is m	2	19a. Informant's Name/Relationsh	-				Address (Street				-	i, State, Zi	p Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		Rebecca L. Barr	ett	(mother			Ocean P	-			•	218	
Fe lar		20a. Method of Disposition 1 Burial 2 Acremation	3 🗆 🛭	Pemoval from S		lace of Dispos ematory or oth	ition (Name of cem erplace)	netery,	Date	20c.	Location -	City or Tov	wn, State
ages ent or nt: I	1	4 Donation 5 Other Sp		temoval nom a	idio		rematory	4-1	1-2006	Ba	1timo	ro l	ďΝ
Iltin artim orta		21. Signature of Furieral Service I			LDay	22. N	ame and Address	of Facility	1 2000	Da	TUTING	,,,,	. ID
Balt permit Departs Import		Alan I		Oat	1	Mo	ame and Address Cully-Po	lyniak l	Funera.	l Hom	e, P.	A.	
Physician		23a. Part I. Enter the disease, or	omplicati	yne Ost	eriing d the death.	Do not enter the	O E. For	C AVE. I	Baltim(or respiratory	ore,	MD Z	:123U	Approximate Interval
/Medical		failure. List only one cause	on each li	ne.					· · - · · · · · · · · ,		,		Between Onset and
Examiner		Immediate Cause (Final disease		strointestina		_							Death
<i>)</i>		or condition resulting in death)		to (or as a con:):							
	_	Sequentially list conditions,		onic Alcoho									
		if any, leading to immediate cause. Enter Underlying Cause		to (or as a con:	sequence of)	r.							
,	am	(Disease or injury that initiated events resulting in death) Last	c. Due	to (or as a con:	sequence of)	1:							
		events resulting in death, East	d.		, ,								
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e be c	Physician/Medical												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	E 2	IF FEMALE: 23b. Was decedent pregnant in th	^	3c. If yes, outco	me of pregn		tal death 3	Ectopic pregn	iano.	23	d. Date of o Month	delivery Day	Year
certi radin	<u>a</u> .	past 12 months?	1		at time of dea	th =	Li douti	Coopic pregn	iaiicy		MOTILIT	Day	i cai
Sox 6 leath cer e attendi for use	Ś	1 Yes 2 No 9 Unk	nown 9	Unknown		3 [_] Ut	ner (Specify)						
P.O. B. res that the de signed by the be detached f	F.	Part II. Other significant conditi			ith but not re:	sulting in the u	nderlying cause gi	iven in Part I.	23e. Di	d tobacco	use contrib	oute to the	cause of death?
ires that the signed by I be detached	à	· • · · · · · · · · · · · · · · · · · ·				3	g				No 3	Probab	
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cords, law requir has been s	Completed								24a. W au	as an itopsy			sy findings available pletion of cause of
e Co ne law te has ge 2 s	Ĕ								1 ✓ Ye	erformed?		eath? Yes	2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	ပိ	25. Was case referred to medical					26 Place	of Dooth /Chook		25 2		Vies	2 140
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Phys rrthii al di	၉	1 ✓ Yes 2 No	1	· I IIIpat		ER/Outpatient					ence 6 🗸		cene
J O L	Ë	27. Manner of Death 1 ✓ Natural 5 □ Rond		28a. Date of In (Month, Day	Jury (Year)	28b. Time of I		y at Work?	28d. Descril	be now inj	ury occurre	ed	
ior:	aţį	_ Fellu	ing tigation				1Y	es 2 No					
ViS or At fter of Sirec	Certification:		not be	28e. Place of	njury - At hor	me, farm, stree	et, factory, office bu	uilding, etc.			and Numbe	r or Rural	Route Number, City
urs a	ert		mined	(Specify)					or I owi	n, State)			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		20a Cartifier	vsician:	To the best of	nv knowleda	e. death occur	red at the time, da	te and place, an	d due to the c	ause(s) ai	nd manner	as started	
the I hin 2 the I	Medical						ion, in my opinion,						
To To	Mec	29b. Signature and title of pertifie		manner stated	1.		29c. License	number		294	Date signe	d (Month	, Day, Year)
	-	255, orginature and title or portine	0									_	, Day, roar,
		1 Charlot	en	W.			O.C.N	vi.⊑.		Арі	il 9, 200	U	
		36. Name and address of person	who comp	oleted cause of	death (Item :	23a)							
5		Laron Locke MD. As	ssistant	Medical Ex	kaminer	111 Penn	Street, Baltim	nore, MD 21	201				
Sta	te	31. Date filed (Month, Dav, Year)		32. Pagistr	ar's Signatur	e	Annual Property lies						
Regist	rar	31. Date filed (Month, Day, Year) APR 1	3 200	6 Men	use I	K May	West .						
DHMH 17 Rev 1/20	01			1	-	ODICINA							
OCME 10/2003	91					ORIĞINA							



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#10e,19b, perFH,0854,4/13/06 IT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician ESTHER** APRIL BERNSTEIN 10 2006 1:04 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2¶F 212-40-4824 66 Yrs Director MD Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show olical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** MD BALTIMORE BALTIMORE 10e. Street and Number High Stepher 2 HIGHSTEPPER COURT APT. #402 10f. Zip Code 10g. Citizen of What Country? 21208 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. WHITE filed within 72 hours after 1 Never Married 2 Marned 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No þ Soecify. 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy important; if Item 27 is marked other any lightly or other traumatic event 9058. 17. Father's Name (First, Middle, Last) Be 18 Mother's Name (First Middle Maiden Sumame AARON **SMELKINSON** JEANETTE ZENT7 19b. WHIGH ASTREE COURT APT. #402 - BALTIMORE, MD 21208 19a. Informant's Name/Relationship (Type, Print) ALLAN L. BERNSTEIN / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MARYTAND VETERANS COLOR GARRISON FOREST ROAD 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/12/2006 OWINGS MILLS, MD 4 ☐ Donation _5 ☐ Other (Specify) Juneral Service Ans 21. Sign we 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Websmore breast uncer yers /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) ed by the attending physicien detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown After this certificate has been signed funeral director, page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Wospilar ဥ 1 ☐ Yes 2 No ţ Briskin, 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospitel of within 24 hours at To the Funeral D. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai Certifying Physician: To the best of my knowledge, deam occurred at the time, date and place, and due to the dause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 APRIL 10 200B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J- CHARLES, mp 6601 N. Charle ST BATTMOR MD 21204 3 Registrar's Signature 31. Date filed (Month Day, Year) State 2006 Registrar

		For State Registrer	State of M		d / Depa		Health ar		tal Hygi	_	6	1150	3
Physicia		Decedent's Name (First, Middle, EUGENE J. BRANNO							Date of Death	٦	80°0	3. Time of De 6:00 AM	
/Medica Examine		4a. Facility Name (If not institution, ARCOLA HEALTH &	REHABILITA			SILVER	or Location of D			4c. County		ORGE 'S	
Funeral Director		5. Social Security Number 579-10-9781 Usual Residence of Decedent	6. Sex 7. A 1 ☑ M 2 ☐ F	ge (In yrs. 9:	last birthday) 2 Yrs.	If Under 1 Yea Months Day		Min. (Date of Birth Month, Day, pt. 28	Year) 3,1913		place (State or Fo ntry) RGINIA	oreign
Maryland a-f show	tor	10a. State 10b. County MD P.G			y, Town or Lo							10d. Inside City L 1 X Yes 2[
th with the 23a or 28	Funeral Director	10e. Street and Number 901 ARCOLA AVEN	UE			10f. Zip Code	20902		10	og. Citizen of USA		ntry?	
ors a	۾	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces od 1 1 1 Yes 2 If Yes, Give Year or Dates	? No		Vas Decedent o I Yes, specify Ci □ Yes 2 1 N	f Hispanic Origir uban, Mexican, F lo <i>Specify</i> :	n? (Specify Puerto Rica	Yes or No- n, etc.)		ck, White	can Indian, etc. 1ack	
within 72 ho iene. Ithen "natu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 8th		5+)	(Give life. I	lent's Usual Occ kind of work dor DO NOT use reti	ne during most o ired)	of working		16b. Kind of E		vernment	
buld be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, L Will Brannon	ast)		1		18. Mother's	s Name <i>(Fii</i> nie Da		faiden Surna	me)		
t and 2 shu Health and Health and Hear traum		19a. Informant's Name/Relationshi Valerie Bloomfi 20a. Method of Disposition			2315		et and Number of Place,		#102,		ngton	,DC 2002	20
nit. Pages artment of i ortant: If it injury or o f.		1 Bunal 2 Cremation '4 Donation 5 Other (Sp. 21. Signature of Funeral/Service L	ecity)		antico	natory or other p	Cemetery	4/1	3/06	Quant	ico,		
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w requires that the de been signed by the should be detached	þ	Part II. Other significant condition HYPERTENSIC		but not res	ulting in the u	nderlying cause	given in Part I.					the cause of death	
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hysician his certific if director.	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2	EP/Outpatier	1 3 DOA	Other: 4፟፟፟ Nurs		he <i>ck only on</i> 5 ☐ Reside	e) ince 6 🗆 Ot	her (Spec	fy)	
To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investig: 3 Suicide 6 Could not determine	ot be 28e. Place of It	ay Year)	28b. Time of Injury ome, farm, str	V	Vork? ☐ Yes 2 ☐ No	0				al Route Numbe	r.
e Hospitai 24 hours a Funerai letely filled	Medical Co	29a. Certifier (Check only one) 1 Certifying 2 Medicel E	Physicien: To the bes xeminer: On the basis and manners	of examina	owledge, death ation and/or in	n occurred at the restigation, in m	time, date and y opinion, death	place, and occurred a	due to the ca	ause(s) and mate and place	nanner as , and due	stated. to the cause(s)	
To th Withir To th	Me	29b. Signature and title of certifier	M				2332		2	9d. Date sign		Day, Year)	
2		30. Name and address of person w	M D D	Α.		0:1-	l Georgi ver Spri				2 - 20 902		
Sta Registra		31. Date filed (Month, Day, Year) APR 1 3	2006 32 Aegis	trar's Signa	To A	arle)							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State o	f Maryl		•	nent of I cate of	lealth a Death	nd Mer		iene Ig. No. () (16	11504
	_		Decedent's Name (First, Middle, Las	st)							Date of Deat	h		3. Time of Death
	Physici /Medio		Jose	S. Ba	arzela	atto				Aı	Month pril 7	, ^{Day} 2006	Year	2:55 P M
	Examir		4a. Facility Name (If not institution, give	street and nu	mber)		4b.	City, Town, o	or Location of	Death		4c. Count	y of Death	
			Suburban Hospita	1				Bethes				Montg		J
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex ⊠M 2□F	7. Age (In	yrs. last birth Y		Inder 1 Year nths Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, ril 4,	^{Year)} 1926	9. Birth Cou Chi	place (State or Foreign ntry) 1e
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c	. City, Town	or Locatio	n						10d. Inside City Limits
	Aaryli Febo	ō	Maryland Montgome	rv		ockvi								1 ☐ Yes 2 ☒ No
	288-	Director	10e. Street and Number	-)				of, Zip Code			10	Og. Citizen of	What Cou	intry?
	3a or	١	5800 Nicholson I	ane Apt	t. 120	01		20852			τ	Jnited	Stat	es
	deatl	ner	11. Marital Status	12. Was Dec	edent Ever	in U.S.	13. Was	Decedent of I	Hispanic Orig	in? (Specify	Yes or No-			ican Indian,
Manyland 21215-0036	partition of the property of the control of the control of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health end Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23s or 28s-f show any njury or other traumatic event, the Medical Exetti far most be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tes If Yes, Gir Year or D	2⊠No ve			es 2⊠ No		rueno nica	in, eic.)	Specia	ick, White fy: W	nite
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Š	thould be and the mark	ဥ	19a. Informant's Name/Relationship (7	vpe. Print)		19b.	Mailing Ad	dress (Street	t and Number	or Rural Ro		City or Town	State, Zi	p Code)
	Md 2 s		Anamaria B. Micha	•	ighter							arylan		0854
9	F Head		20a. Method of Disposition		20	b. Place of I	Disposition			Date		20c. Location		
8	Page nt: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					ematori		200		Retheso	la. M	aryland
<u>:</u>	permit. Pages 1 ar Department of Hea Importent: If item: any injury or other		21. Signature of Funeral Service Licen		400092									neral Home venue
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ه در	res that igned b	by P	Part II. Other significant conditions of	ontobuting to d	eath but not	t resulting in	the underl	ying cause gr	ven in Part I.			_		the cause of death?
OSE	w requires been signi should be	ted								_	1 □ Ye	s 2□No	3 Pro	bably 4 🖫 Unknown
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	nding Physician: nding Physician: sth. r: After this certifica e funeral director,	မှ	1 ☐ Yes 2 🖾 No			2 ER/Out		LIDOA		sing Home	5 🗌 Reside	nce 6 □Ot	her (Spec	ify)
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R-EELMI 10, Division of Vital	or Air by	Certification:	4 Homicide determined	286. Place	ing, etc. (Sp	ecify)	m, street, i	actory, office		281.	City or Town	n, State)	ber or Hui	ral Route Number,
15AR SELMITO	To the Hospitel or Attending Physician: The lawithin 24 buours eiter death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 🔀 Cartifying Ph	niner: On the b	best of my asis of examiner stated.	knowledge, mination and	death occivor investi	urred at the togation, in my	ime, date and opinion, death	I place, and h occurred a	due to the ca	ause(s) and mate and place	anner as , and due	stated. to the cause(s)
	Fo the within 2 Fo the comple	Me	29b. Signature and tyle of certifies	1	0			29c. Licen	se number		2	9d. Date sign	ed (Month	Day, Year)
	->= 0		+ faut 1	LA Mu	10.	10		DOO	6108	33	1	APRIL	9	2006
	• 0		30. Name and address of person who	completed caus	se of death	(Item 23a) (1	Гуре, Print		- ()				.10	
_	10		Paul Thambi, M.D.	9707	Medica	al Cen	ter I	rive,	#300, 1	Rockvi	111e, 1	Maryla:	nd 20	850-3365
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 3 2	2006 32. 6	leģistrar's S	signature	Mag	18 0						

6-02387 aker, Pamela		S	Pleastate of Mary	se Type o					vaiono				
,	F	- For State Registrar			ertificate o			i ivientai n		Reg. No.	200	16	1150
Physiciai Medical Examin	-	1. Decedent's Name (First, Midd Pamela	_{lle,Last)} J. Baker						2. Date of D Month April 7,		Year	3.	Time of Death 9:38
	4	4a. Facility Name (if not institution Suburban Hospital	on, give street and r	number)			Town, or Linesda	ocation of Death		4c.	County of D		
Funeral Director	_	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Und	der 1 Year ths Days	If Under 24Hrs Hours Min.				Countr	ace (State or Foreigry)
	1	324-46-6378 Usual Residence of Decedent	1 M 2XF	55	Yı	rs	o Bayo	Tiodio William	August	14,	1950		
Maryland 28a-f show any <u>d at once.</u>		10a. State 10b. County Maryland Montg			y, Town or Loca evy Cha								d. Inside City Limits X Yes 2 No
the Marylina or 28a-f	Director	10e. Street and Number 5607 Montgome	ry Street				ip Code 0815				zen of What ed Sta	-	?
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once	Fune	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Di	Married Armed 1 Yes vorced If Yes, Give Y		J.S. 13. W	Yes, spec	dent of Hisp cify Cuban, 2 X No	panic Origin? (Sp Mexican, Puerto specify:	ecify Yes or Rican, etc.)	No-	White, e		Indian, 8lack,
21 - 12	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	or Dates: ecify only highest gr		during most o	ent's Usua of working	Ife. DO NO	on (Give kind of v	vork done		Kind of 8usin		
5-0036 iled within 7 Hygiene. I other than		17. Father's Name (First, Middle			Aquat	ics		V1SOT 8 Mother's Name	(First, Middle		MCA Surname)		
2121 ould be fi I Mental s marked ic event,	To Be	James Baker 19a Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Addres	ss (Street	Esther and Number or F	Rural Route N	Sigm Number, C		State, Zi	p Code)
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumant.	2	Matthew C. Star 20a. Method of Disposition 1 8urial 2 Crematio 4 Donation 5 Other S 21 Signature of Fugeral Service	on 3 Removal	20b from State	Place of Dispo crematory or co Dntgomery	osition (Na other place V Cren Name an ethe	ame of cem e) natoriu d Address (sda-C)	Apr m 10	ril , 2006 pert A ase, I	Be Pum	cthesd phrey 557 W	a, M	land 20815 Van, State (aryland eral Home nsin Avenu
Physician /Medical Examiner		23a. Part I. Enter the disease, o failure. List only one cause Immediate Cause (Final diseas or condition resulting in death)	e on each line. e a Ath e		h. Do not enter	the mode	of dying, s	such as cardiac o					Approximate Interval Between Onset and Death
p is	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e c.	a consequence									
executerian and all trans	g	X UNPENDED	d. AMENDED	item#	23a,PII,2	27,per	mE,G85	4,4/19/06	TT				
Box 68760, e death certificate be the attending physic ed for use as the burner		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 ✓ Ur	the 1 Live	s, outcome of pre	gnancy 2 F	Fetal deatl Other (Sp	h 3	Ectopic pregna		230	d. Date of de Month	livery Day	Year
, P.O. B res that the d signed by the be detached		Part II. Other significant condi Prolonged QT int	itions contributing	to death but not	resulting in the	underlyir	ng cause gi	ven in Part I.		d tobacco Yes 2	_		cause of death?
Records The law requirecte has been page 2 should	Completed by								ре	as an topsy rformed? s 2 N	prio dea	r to com	sy findings available pletion of cause of 2 No
f Vital Physician: or this certi	To Be	-	Hospital: 1 28a, Dat (Mor	Inpatient 2 to the of Injury (th, Day, Year)	✓ ER/Outpatien 28b. Time of		DOA C	of Death (Check Other Nursin y at Work? es 2 No				Other:	
Division spital or Atta hours after de meral Directo y filled in by t	Certification:	3 Suicide 6 Cou	ermined (Specif						or Towr	n, State)			Route Number, City
thin 24 lint the Fu	<u>'</u>	1	Physician: To the basi	s of examination	-								ause(s)
T. v.	¥ :	29b. Signature and title of certification	and manner			25	9c, License O.C.M				Date signed	(Month	, Day, Year)
	;	30. Name and address of perso	n who completed ca	use of death (Ite	m 23a)								

Registrar

State 31. Date filed (Month, Day, Year)
APR 1 3 2006



			1 - For State Registrar	State of M	laryland / D			Health a			ene	6	1506
	Discortant		1. Decedent's Name (First, Middle, Last)							Date of Death Month	Day	Vana	3. Time of Death
	Physici /Medio		Daniel		Charles	B	elle	Jr.		4	10	Vear O6	2030 PM
	Examir	er	4a. Facility Name (If not institution, give s			4b.	City, Town,	or Location of	of Death		4c. County	of Death	
			Linguersity Specially			B	altim	dre	0.111			N/A	
	Funeral Director		5. Social Security Number 6. Sex 218-44-2841	M 2□F 7. A	ge (In yrs. last birth	mor rs.	nder 1 Year iths Days		Min.	Date of Birth Month, Day, 1		9. Birthpl	ace (State or Foreign try)
			Usual Residence of Decedent		61 Y				L M∂	arch 13	3,1945	Mar	^ý1and
	larylanc show		10a. State 10b. County		10c. City, Town	or Location						10	0d. Inside City Limits
	a-fs	ctor	Maryland Anne Aru	ndel	Pas	adena	t						1 ☐ Yes 2 📉 No
	or 28a-f	Director	10e. Street and Number			10	f. Zip Code			10	g. Citizen of V	Vhat Coun	try?
	death with the Maryland ms 23a or 28a-f show rmust be notified at		212 Glen Road				21	122			US	Α	
	ar dea	Funeral		Was Deceden Armed Forces	?	13. Was D	ecedent of I specify Cub	Hispanic Ori	igin? (Specify n, Puerto Rica	Yes or No- n, etc.)		e - America	
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 If Yes, Give			es 2⊡√No				Specify		
5-0036	turai	ed t	15. Decedent's Educ	Year or Dates:		Paradant's	Usual Occur	nation		1 1	6b. Kind of Bu		nite
(within 72 hours after ene. than "natural", or ita te Modica Evantina	Completed	(Specify only highest grade	completed)	(Give kind o		during mos	t of working	"	oo. Kind of bu	siness/ind	lustry
ie (d with giene. ir thar	mo	Elementary/Secondary (0-12)	College (1-4or	,	Truck	Drive	ar			Tr	uckin	ıa
	e file al Hyg otha vant,	Bec	17. Father's Name (First, Middle, Last)			1144		_	er's Name (Fir	st, Middle, Ma			9
da	2 should be filed within 72 hours after death w and Mental Hygiene. Is marked other than "natural", or itams 23a aumatic evant, Its Modical Examiner must k	10 E	Daniel	С.	Be	lle	Sr.	н	lattie		un	known	
$D_{\!\!\!2}n$ Maryland	12 should be filed v n and Mental Hygie 7 is marked othar t raumatic evant, ID		19a. Informant's Name/Relationship (Typ	e, Print)					er or Rural Ro		City or Town,		
_ <u>`</u> ≥	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e1 shor or other traumatic event, the Modical Eventiner must be notified at		Kenneth Hicks	son	2	12 GT	en Roa	ad Pas	adena.	MD 211	22		
ore	ges 1 t of H if ital		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	20b. Place of L	Disposition crematory	(Name of	ice)	Date	20	Oc. Location -	City or Tov	wn, State
altimor	Pa nen ant: ury		* 4 ☐ Donation, 5 ☐ Other (Specify)	. 0	' Metro			1		06	Baltimo	ore M	D
Bal	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licence	4/1		22. Nam		ess of Facilit	Stai	lings H	- Funera	l Hom	е Р Д
	TO 2 4 0		14 a. S	1		311	1 Mour	ntain	Road Pa	asaden:	a MD 2	1122	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	use on each	ine.	ot enter the	mode of dyi	ng, such as	cardiac or res	spiratory arres	st,		Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	Coroni	ary au	terry	dis	case	with	conjo	struc		Oliset and Beatin
	Examiner		ſ	4.	s a consequence of):		,	has	nt fa	Think	_	_
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Υ,	be executed ician and burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as	s a consequence of		<u> </u>	wirk	penj	dise	ase	ei	103-
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dicai	d.										
9	tifical ng phy as th	ledi											
Вох	eath certific attending p	Physician/Me	200. Has decedent pregnant	c. If yes, outcome	e of pregnancy 2 Petal death	3∏Ector	ic pregnanc				23d. Dat	e of deliver	
Э.	ne deat the att	sicis	in the past 12 months? 1 Yes 2 No		at time of death		r (specify) _				Mo	nth i	Day Year
P.O.	that the de ad by the detached	Phy:	9 🗆 Unknown										
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oro	requi	ted								1 ☐ Yes	2 No	3PT Proba	ably 4 Unknown
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=	sician: The certificate ha	Con								performe 1 □ Yes 2	ad? c	leath?	
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	amitali.					of Death (Ch	eck only one)			
o	Phys this al dir	7	1 ☐ Yes 2 ☑ No ☐ ☐ 27. Manner of Death	spital: 1. Inpati			DOA		rsing Home)
no	ding F h. After funera	tion	1° ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Tir ay Year) Inj	ne or ury M	28c. Inju Wo	ryat rk?]Yes 2.∐I		Describe how	injury occurr	be	
Division of	deatl deatl ctor: y the	lical	2 Accident investigation 3 Suicide 6 Could not be	28e Place of In	iun/ - At home, fam					ocation /Stra	ot and Numb	or or Pural	Route Number,
<u> </u>	i or At after d Diract J in by	Certifications	4 ☐ Homicide determined	building, e	ijury - At home, fam tc. <i>(Specify)</i>	ii, siicei, ia	ctory, office		201. (City or Town.	State)	si Oi Muidi	Houle Namber,
	spitai nours a naral [29a. Certifier 12 Certifying Physi	cian: To the best	of my knowledge.	death occu	rred at the ti	me date an	d place, and o	due to the cau	se(s) and ma	nner as sta	hate
	To the Hospitel or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fu	edical	(Check only 2 Medical Exeminations)	er: On the basis of and manner si	of examination and/	or investiga	ition, in my	opinion, deal	th occurred at	the time, date	e and place, a	and due to	the cause(s)
	withir To the To the Comp	-	29b. Signature and title of certifier				29c. Licens	se number		290	d. Date signed	(Month, E	Day, Year)
			· CMehtai	UD			1) 3	497	14	1	pril	1170	2006
	1		30. Name and address of person who con	pleted cause of	death (Item 23a) (T	ype, Print)	1 . 1		ta /	77.1	Jilai K	Va r	UD217 PA
_	\		30. Name and address of person who con CHARU MENTA	, MJ 6	11, Sout	he	ray	es 27	reet	1500	J. M. O	12,	12240
	Sta Registr	te	31. Date filed (Month, Day, Year) APR 1 3 2006	32. Regist	rar's Signature	will	•						
			WILL T & FOOD	Jan Sales									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item #18 Per FH G854 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Pri **Physician** 2006 22; 13 M Revnold Bunk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 F Days Hours Min 215-12-1549 Director 92 May 26 1913 Maryland Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other than "netural", or items 23a or 28e-f show other treumstic event, the Neulcal Examinar must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8413 Woodland Road 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married timore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within and Mental Hygiene.

Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Construction <u>Carpenter</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Runk Elise M. Fricke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an E. Wayne Bunk son 421 Lambeth Road Catonsville Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of I ant: If It 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery! 4/18/2006 | Glen Burnie MD 21. Signature of Juneral Service Licer 22. Name and Address of Facility Stallings Funeral Home P.A. <u>3111 Mountain Road Pasadena MD 21122</u> 23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate shocks are the statement of th that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fina disease or condition resulting in death) **Physician** Vere /Medical to (or as a consequence of) **Examiner** Thromboestopend Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a nonsequence of Examiner burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes Other: P 2 No 1 EInpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. May er of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funerel Diractor: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year), AOVN U 2006 30. Name and address of person who completed cause of death fliem 23a) (Type, Print) Drive Jedvas 32. Registrar's Signature **3** 2006 State Registrar

DHMH 17 Rev 1/2001

Bunk, Roynol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ind Items 10b-f per fh 2054 4-13-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Пау Year **Physician** Willie Mae 09 8:35 Clack April 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 104 Sun Mar Court Apt. 3C Gwynn Oak er 1 Year | If Under 24 Hi Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 20 F Days Months Hours Min 80 251-26-3438 Yrs. Director 12/25/1925 South Carolina Usual Residence of Decedent Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "neturel", or items 23s or 28s-f show other traumatic event. Its Medical Examinar must be notified at Baltimore Gwynn Oak 1 No 2 No Director Maryland -Baltimore the 10e. Street and Number 104 Sunmar Court Apt. 10g. Citizen of What Country? 3c 10f. Zip Code 21207 U.S.A. 21215 Avenue 3336 St. Ambrose. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: Black 3 XWidowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within and Mental Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Housewife 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Montgomery Bethany Stuckey ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Sun Mar Court, Apt. 3C, Gwynn Oak, Maryland 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 le m eny injury or other traum 104 Sun Mar Court, Apt. Dionna Witherspoon / Granddaughter 21 207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 04/15/2006 Landsdowne, Maryland Zion Cemetery al Sente Licensee 22. Name and Address of FacilityThe Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Par(1. Enter the disc shock or Meart failu Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death disease, or complications that caused the death. failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Box 68760, physicien certificate be Physician/Medical as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 mos Month Dav Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ HKnown 1 ☐ Yes 2 ☐ No funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2 D No 1 ☐ Yes To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certified Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 2 1 Tes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Datural Injury 5 Pending 1 Tes 2 No investigation 2 Accident filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 🗓 🚅 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and a dress of pe

DHMH 17 Rev 1/2001

State

Registrar

31. Date

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2006

n .	-032		For State Registrar	State of Marylar		ment of H			ene 9. N2 0 0 6	11509
	Dharia		Decedent's Name (First, Middle, La					2. Date of Death Month		3. Time of Death
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	Examir	ner	4a. Facility Name (If not institution, gi	ila elin Il	a / 1 / 4b.	City, Town, or	Location of Death		4c. County of Dea	ath
	Funeral	-	5. Social Security Number 6.	Sex 7. Age (In yrs.	last birthday) If I	Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bi	nthplace (State or Foreign
н	Director			1□M 2€F 63		onths Days	Hours Min.	8. Date of Birth (Month, Day, NOV • 4 •	1942 Nor	th Carolina
	pu .		Usual Residence of Decedent 10a. State 10b. County	100.00	ty, Town or Locatio					Tana tanàna and tanàn
	Aaryla Febov	ō	MD Prince		on Hill	n				10d. Inside City Limits 1 1 Yes 2 □ No
	be filed within 72 hours efter death with the Maryland lai hygiene. Id other then "naturai" or leme 23a or 28e-f ehow event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number	0001800		Of. Zip Code		10	g. Citizen of What C	
	h with	0	717 Marcy Ave.			2074	4.5		USA	,
	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was I		ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
36	or it		1 Never Married 2 Married	1 ☐ Yes 2X No		res 2. DXNo	Specify:	riiodii, otc.)	Black, Wh	ite, etc.
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5.	in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Decedent's (Give kind life. DO N	of work done of IOT use retired	during most of work	ing	6b. Kind of Busines:	s/industry
212	d within giene. or then "	omi	Elementary/Secondary (0-12)	College (1-4or 5+)	Bus Ope	erator		P	G Brd of 1	Education
B	should be filed with and Mental Hygiene marked other the imatic event, Institute in the imatic event e	Bec	17. Father's Name (First, Middle, Las)			18. Mother's Nam	e (First, Middle, M		20.00.00.00.00
yla	should be ind Mentail marked o	2	McDaniel Whitake				Grad	y Wade		
Maryland	2 g = 3		19a. Informant's Name/Relationship	•					City or Town, State,	Zip Code)
	s 1 end of Heelth item 27 other to		Mack Daniel Whita 20a. Method of Disposition		_ 4939 Win		St. Oxo		1d. 20745 0c. Location - City o	
JOI	80= 5		1 ⊠Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	☐Removal from State	cemetery, cremator	y or other plac	(a)	1		
Baltimore,	프는민준 .		21. Signature of Funeral Service Lice		Lincoln	me and Address	ss of Facility	- Constitutions	Brentwood,	V-172-272-
ä	Depa Impo eny i		P P Marche	ell	Mars 421	shall's 7 9th S	Funeral	Home, Inc	on, DC 20	0011
			23a. Park. Enter the disease, or con shock, or heart failure. List only	one cause on each line.	th. Do not enter the	mode of dying	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. IVC INTURY	DURING	REMO	OVAL OF N	RETASTATIC	LIVER TUMB	Onset and Death
	/Medical Examiner		resulting in death)	Due to (0) as a consec	qualica oi).					
		1	Sequentially list conditions,	b. METASTATI		OENDOC	RINE TU	MOIL OF	LIVER	YEAR
1	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		donos ory.			1 .		
O	be executed sicien and burial-transit		that initiated events resulting in death) Last	C. Due to (or as a consec	quence of):		71	Venil	CAL EXAMINER	
8760,	death certificate be executed e ettending physicien and od for use as the burial-transit	Physician/Medical	(d			/ /	A ROYED BY MEDIC		
9	n certifica ending ph use as t	Med	IF FEMALE:				CERTIFICATION	pr 🔾		
Вох	eath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta	al death 3 □Ecto	pic pregnancy	1		23d. Date of de Month	alivery Day Year
P.0.	thet the dended by the education of the detached	iysic	1 ☐ Yes 2 📜 No 9 ☐ Unknown	4∐Pregnant at time of d 9□ Unknown	seath 5 ☐ Oth	er (specify)				
	iaw requires thet the es been signed by th 2 should be detache	by Pr	Part II. Other significant conditions	contributing to death but not res	sulting in the underly	ying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Division of Vital Records,	w requires t been signe should be	ed b						1 🗆 Yes	2 2 (No 3 □ F	robably 4 Unknown
900	iaw re 9s be 2 sho	Completed						24a. Was an	24b. Were a	utopsy findings available completion of cause of
Œ	The ete h page	E O						autopsy perform		
/ita	sicien: certific rector,	Be (25. Was case referred to medical examiner?					h (Check only one	10.0	
6	Phys this aldi	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 > npatient 2 2			4 Nulsing Ho		nce 6 Other (Sp	ecity)
5	ding h. After fune	tion	1 □Natural 5 □ Pending	(Month, Day Year)	28b. Time of Injury 9:53 A N	28c. Injury Work	yat (? Yes 2 X No	28d. Describe hov Inferior	vena cava	a tear
/isi	or Attending efter death. Director: After in by the fune	ifica	3 Suicide 6 Could not b	28e. Place of Injury - At h	ome, farm, street, f			28f. Location (Stre	urgery eet and Number or F	Rural Route Number,
Ö	s effer s offer of Dire	Certification;	4 Homicide determined	building, etc. (Specia	Mospit	al		600 N. OW	olfe Street, Marylar	et d
	To the Hospital or Al within 24 hours effer of To the Funerei Direc completely filled in by	edicai	29a. Certifier the Cartifying Plant (Check only 2 Medical Exa	nysician: To the best of my kno miner: On the basis of examina	owledge, death occu	urred at the tim	e, date and place.	and due to the car	use(s) and manner a	s stated
	To the within 2. To the Complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License				
	5 3 £ 8		Myn Z(ON	eun RESIDER	5			f	d. Date signed (Mon	
	4		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type Print)				Apicic 0	3 2006
			MICHAEL G. House	M.D. 600 N	WOLFE	STREET	- Touen	110 BA	TIMORE	5 2006 MD 21287
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa						

			1 - For State Registrar			Depa		Health and M Death	lental Hy		nns	15	10
1000	n		1. Decedent's Name (First, Middle, Las	,					2. Date of De Month	ath Day	v Year	3. Time o	of Death
1	Physici /Medio		Virginia	Patricia	. Crow	1ey			April 8		006	5:45	5 A ^M
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location of Death		4c.	County of Death		
			Manor Care Potor	nac			Potomac				ntgomer	y	
	Funeral		5. Social Security Number 6. Se	DM offic	e (In yrs. last i		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March 2	th ay, Year)	9. Birth	place (State intry)	or Foreign
	Director		307-20-4320	¹ 78		Yrs.			March 2	1, 19	928 Mic	nigan	
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Lo	ocation					10d. Inside C	City Limits
	/aryli	ច		¥37	Rock								s 2 ⊠ No
	28a-	Director	Maryland Montgome:	- y	ROCK	V T T T	10f. Zip Code			10a Cit	izen of What Co	inter/2	
	within 72 hours after death with the Maryland she. than "naturel", or iteme 23e or 28e-f ehow ta Madisal Examinar mail be notified at	ā	1515 Dunster Road				20854		ŀ	-	ed State		
	ne 23	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13.		Hispanic Origin? (Sp			14. Race - Amer		
10	riter	T.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N		1		dispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White	, etc.	
036	urs a	ρ	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1⊡Yes 2∏xNo	Specify:			Specify: W	hite	
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra-	ucation	16	Sa. Dece	dent's Usual Occup	pation	(10.0	16b. K	ind of Business/I	ndustry	
21	thin an	ηple	Elementary/Secondary (0-12)	College (1-4or 5	+)	lite.	DO NOT use retire	during most of work d)	ung				
2	er th	00	£ 4.	2		Но	memaker			0	wn Home		
nd	al Hy	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nam	_				
Va	Ment Ment mrke arke	P	David H. Crowley					Nin	a Bar	rett			
Maryland	is 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than other traumalic event, the Ma		19a. Informant's Name/Relationship (7					and Number or Rur					0.10
≥,	and ealth m 27 ner tr		Kathleen Crowley-	Fisher/Daug				Drive El					043
ore	of H of H it its		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	20b. Place ceme	of Dispo	sition (Name of matory or other pla		Date 1 11,	20c. Lo	ocation - City or	own, State	
Ë	Pages ment of h ant: if its ury or of		4 Donation 5 Other (Specify		Mont	_	ry Cremat	corium 2	006		hesda, M	-	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "nature!, or iteme 23e or 28a-1 ehow amportant: if Item 27 is marked other than "nature!, or iteme 23e or 28a-1 ehow amportant: if Item 27 is marked other traumatic event, its Medical Examinar mast its notified at QDES.		21. Signature of Funeral Service Licen		092	R R	Name and Address Ockville	ess of Facility Ro , Inc. 30 , Marylan	bert A. O West d 20850	Pum Mont	phrey Formery	ineral Avenue	Home/
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	by Secution of the secution of	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Curry by the run of the condition											
P.O. Box 68	The law requires that the deeth certificate be executed ate has been signed by the attending physicien and page 2 should be delached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pregnanc Other (specify)	у			23d. Date of deli Month	very Day	Year
0.	uires that signed b d be deta	by Pi	Part II. Other significant conditions of	ontnbuting to death be	ut not resulting	g in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of	death?
Records,	quire in sig uld b	pe p	precumani	CA					1 🗆	Yes 2	□No 3□Pro	obably 4	Unknown
00	sw requir s been si should	Completed	Find Ibaa.	Renal	disc	CIA	1		24a. Was		24b. Were au		
R	: The law cate has b	E	- crop stary	THE COURT	<u> </u>	الما				ormed?	death?	ompletion of	cause of
Vital	ician: Th certificate rector, pag	a	25. Was case referred to medical					26. Place of Deal	1 Yes	2 No	1 ☐ Yes	2)(2) No	
>	Physician: this certificatal director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Innatie	nt 2 ER/	Outnatier	nt 3 DOA Ot	nor			6 ☐Other (Spec	164	
of	ding Phy h. After thi funeral		27. Manner of Death	28a. Date of Injur	ry 28t	o. Time o		~	28d. Describe			y/	
Division	ath. r: Aft e fun	atlo	1 Accident 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y rear)	Injury		Yes 2 No					
Vis	i or Attendi after death. Director: A I in by the fu	il le	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-	ury - At home,	farm, sti	reet, factory, office		28f. Location City or To	(Street ar	nd Number or Ru	ral Route Nu	m <i>ber</i> ,
Ö	s afte	Certification:		building, etc	c. (Opacity)				Only or 10	iwii, State	9)		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination	dge, deat and/or in	h occurred at the to vestigation, in my	me, date and place, opinion, death occur	and due to the red at the time	cause(s date an) and manner as d place, and due	stated. to the cause	(s)
	To the within To the comp	Me	29b. Signature and title of certifier				29c. Licens				ite signed (Monti	n, Day, Year)	
	-) W)			D005	14566		419	8106		
	1		30. Name and address of person who										
	. 1		Sunitha Blogar	3 Aegistra	A Ecen	+ TC	PPA ROTA	d. Seit	1230 -	TOL	SON M	10212	-81
100	Sta	ite	31. Date filed (Month, Day, Year)	O.S. Registra	ar's Signature	1	and I	,					- La

			1 - For State Registrar	State o	f Marylar		artment of H		and M		iene	006	11511
	Physici	an	Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Yeer	3. Time of Death
	/Media		Warren W. Coo							April 1	-	006	10:30 AM
	Examir	er	4a. Facility Name (If not institution, 12807 Hannah		mber)		4b. City, Town, or		of Death			County of Dea	th
		-		S. Sex	7. Age (In yrs.	last hirthday)	Cumber1		24 Hrs.	8 Date of Birth		legany	thplace (State or Foreign
ļ,	Funeral Director		215-20-9612 Usual Residence of Decedent	1₩ 2□F	83	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, Jan 2,	Year) 1923	Co	ountry)
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	a-f at	ctor	MD A11	egany	Cum	berland	i						1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citiz	en of What Co	ountry?
	ath w		12807 Hannah D				21502				1	USA	
Baitimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "netural", or items 23e or 28e-f ahow evant, tra Medical Exercising trains Le multied at	by Funeral	Narital Status Never Married 2 ☐ Marrie Widowed 4 ☐ Divorced	Armed Fo	2 🗆 No	4	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Orig in, Mexican Specify:	gin? (Spe I, Puerto I	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit Specify: Wh:	e, etc.
Ž	2 ho	ted	15. Decedent's				ient's Usual Occup				16b. Kir	d of Business	
2	within 72 ene. than "nat	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	I-4or 5+)	life. I	kind of work done of DO NOT use retired	during most ()	t of workir	ng			
7	filed with Hygiene. other than	Con	12	8		Dent	ist					lth Ca	re
ב	t be filed ntal Hygi ed other evant, I	Be	17. Father's Name (First, Middle, L.	ist)				18. Mothe	r's Name	(First, Middle, M	Maiden .	Sumame)	
<u> </u>	should be nd Mental marked o	ို	Walter Lee Cook							ces Bea			
<u>a</u>	0 42 25 2		19a. Informant's Name/Relationshi				ng Address (Street a						
a	1 an Heal em 2 ther		Terry L. Jones/	laughter	20b. P	21 Br	adshaw Co	ourt S				ation - City or	
و	Peges nent of int: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3			emetery, cren	natory or other plac	Θ)			200. 100	ation - only or	Town, State
	그 문문을		* 4 ☑ Donation 5 ☐ Other (Special Section 21. Signature of Funeral Service Li	• • • • • • • • • • • • • • • • • • • •	7	22	. Name and Addres	s of Facility	v				
ğ	Depa Impo any is		Ropald S) Lect	r Si	tate Anat	omy B	oard	655 W.	Ba1	timore	Street
Sa	-		23a. Part 1. Enter the disease, or	omplications that c	aused the deat	h. Do not ent	altimore, er the mode of dym	g, such as o	cardiac or	r respiratory arre	est,		Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition	lly one cause on e	AVD MA	ue or	tey 1	hecas	P				Interval Between Onset and Death 3 4
	/Medical		resulting in death)	a. Due to (or as a conseq	-0	- 1	13000					3 943
	Examiner		Construction to the second state of	b									
29	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq	uence of).							
	acute ind trans	Examine	that initiated events	с.									
Ď,	cate be executed physicien and the burial-transit	Ē	resulting in death) Last	Due to (or as a conseq	uence of):							
9/80 8/60	The law requires that the death certificate be executed the has been signed by the attending physicien and sage 2 should be detached for use as the burial-transit	dicai	·	d								_	
×	v requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, out	come of pregna	incv							
X Q	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live b	irth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)				2	3d. Date of del Month	Day Year
j.	y the	ysi	1	9□ Unkno		Julii 5 _	Other (specify)	-					
 T	that	by Pł	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the ur	nderlying cause give	en in Part I.		23e. Did tob	acco us	e contribute to	the cause of death?
Vital Records,	quire: n sign	q pe	Interstit	ial L	ent o	iscers				1 🗆 Ye	s 2 5	(No 3 □ Pr	obably 4 Unknown
ပ္ပ	s been s	Completed			O					24a. Was ar	n	24b. Were au	utopsy findings available
ř	ding Physicien: The lav h. After this certificate has funeral director, page 2	шо								autops	ned?	prior to death?	completion of cause of
		0	25. Was case referred to medical	T				26. Place	of Death	1 ☐ Yes 2	e)	1 4 4 4 5	2 110
> 0	nysicien: nis certific director.	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 I	npatient 2	ER/Outpatien	t 3 DOA Othe	er: 4 □ Nur	rsing Hom	ne 5 Reside	ence 6	□Other (Spe	city)
0	ding Ph h. After th funeral		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	28c. Injury Work	at c?		8d. Describe ho			
<u>0</u>	Itendi Jeath. Itor: A the fu	cati	2 Accident investiga					Yes 2□N	No				
DIVISION	tal or Ati	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place	of Injury - At hong, etc. (Specify	ome, farm, stre y)	et, factory, office		2	8f. Location (Sti City or Town	reet and n. State)	Number or Ru	ural Route Number,
	To the Hospital or Attending Physicien: whin's 2 hours after deals are the centlica To the Funerel Director. After this centlica completely filled in by the funeral director. I	edicai (29a. Certifier (Check only one) 1 Certifying 2 Medical Expone)	Physician: To the caminer: On the ba and mann	asis of examina								
	To t Withi To tl	Ž	29b. Signature and title of pertifie	/			29c. License	number		25	9d. Date	signed (Mont	h, Day, Year)
			N/	- fue			Doo	3328	υ		Apri	115,2	001
			30. Name and address of person with			23a) (Type, i	29c. License Da o	625	ken	e Are			1
			SUNIL		2087	A	NO	Ca	inke	uland	MI	2150	
	Sta Registr		31. Date filed (Month, Day, Year)	2006	egistrar's Signa	ure A	all de						

06-0238	34
Dutton,	William

Physiciai Medical Examin

Funeral Director

any

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If Itean 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once

Physician /Medical Examiner

Baltimore, MD 21215-0036

1- For State	Pleas State of Maryla	e Type or Pr and / Departn <i>Certifi</i> d	nent of	Health				/giene		201	16		
Registrar 1. Decedent's Name (First, Mid	dle.Last)	Certino	sale UI	Dealli				2. Date of D	Reg. No.		2 7	Time of Death	
William	В.		Dut	ton				Month April 7,	Day	Year		9:05	'
4a. Facility Name (if not institut		ımber)		b. City, Tov	vn, or Lo	ocation o	f Death	7 фін 7 ,		. County of	Death		
Harbor Hospital			į	Baltimo	re						N/A		
5. Social Security Number	6. Sex	7. Age (In yrs. last bi	rthday)	If Under	1 Year	If Unde	r 24Hrs	8. Date of	Birth (MM.		9. Birthpla	ice (State or I	Foreig
284-54-5350 Usual Residence of Decedent	1 M 2 F	51	Yrs.	Months	Days	Hours	Min.	12/2	29/19	54	Country West	Virg	ini
10a. State 10b. County	/	10c. City, Tow	n or Locati	on							100	Inside City	Limits
Maryland	N/A	Ba1	timor	e							1	VYes 2	No
10e. Street and Number 515 Arsan Ave.				10f. Zip Co	ode 212	225			10g. Citi	zen of Wha	t Country?		
11. Marital Status 1 Never Married 2 1	Married Armed Fr 1 Yes ivorced If Yes, Give Yes or Dates:	2 No	1	s Decedent es, specify (Yes 2	of Hispa Cuban, I No	anic Orig Mexican, specify:	Puerto I				American etc. Whit	-	i i
Elementary/Secondary (0-12		1-4 or 5+)	most of v	vorking life.		T use ret	tired)				Emp1		
17. Father's Name (First, Middl	e, Last)				T	.Mother's	s Name	(First, Middle	e, Maiden				
John	Chester		Dutt	on		Ver]	lie				Pac	:k	
19a. Informant's Name/Relation	iship (Type, Print)	19	9b. Mailing	Address	(Street	and Num	ber or R	tural Route N	lumber, C	ity or Town	State, Zip	Code)	
Stephanie L. 20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other 21. Signature of Funeral Service	on 3 Removal fr	20b. Place	of Disposi atory or oth Have	tion (Name ler place) n Mem ame and Ac Cully	of ceme	tery f Facility y n 1 a	04/ ak F	Grove Date 12/06 Juneral Ave. H	G1 Hom	en Bu	City or Tow rnie A.	n, State Mary 1a	and
23a. Part I Enter the disease, of failure. List only one caus Immediate Cause (Final disease)	e on each line.		not enter th	e mode of o	dyin g , su	ich as ca	rdiac or	respiratory a	arrest, sho		t A	pproximate Ir etween Onse Death	
or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c.	ensive arter: a consequence of): a consequence of): a consequence of):	10sc.te	rotic (carqı	ovasc	ular	diseas	е				
X UNPENDED	AMENDED	item#23a,27	,perME	,g854,4	/27/	06 TI							
IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U	the 1 Live b	ant at time of death	2 Fet	al death ner (Specify	3	Ectopic	pregnar	ncy	230	d. Date of d Month	elivery Day	Yea	ar
Part II. Other eignificant cond	9 Unknown		na in the u	adashuaa as	uoo oiu	on in Bo	et I	OZa Dia	l tabassa				L-0
Part II. Other significant cond	contributing to	o ocali i bul not restitti	ng in the ti	ndenying Ca	iuse yiv	ci iii Fal	i.i.		robacco res 2	_		ause of deat 4 Unkr	
									opsy form <u>ed?</u>	pri de		y findings ava letion of caus	
25. Was case referred to medic	al			26.	Place o	f Death (Check o				-		
examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2 🖊 ER/0	Outpatient	3 DOA	0	her ₄	Nursing	Home 5	Reside	ence 6	Other:		
27. Manner of Death 1 X Natural 5 Rec	28a. Date (Month	of Injury 28b. , Day, Year)	Time of In			at Work?		28d. Describ	e how inju	ury occurred	i		

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certificati

2 Accident

29a. Certifier (Check only one)

Suicide

Homicide

Laron Locke MD.

3

4

29b. S

State Registrar

31. Date filed (Month, Day, Year)

Investigation

30. Name and address of person who completed cause of death (Item 23a)

(Specify)

and manner stated.

6 Could not be



28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City

April 8, 2006

29d. Date signed (Month, Day, Year)

or Town, State)

DHMH 17 Rev 1/2001 OCME 10/2003

			1 - For State Registrer	State of M	laryland /	•	irtment of F tificate of i	lealth and N Death	, ,	giene Reg. No.	6	11513
	Obveisi		1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici: /Medic		NINA LOUISE I	URHAM					APRIL	1, 200	16	11:30AM M
	Examin	er	4a. Facility Name (If not institution, give				•	Location of Death		4c. County		
_			Forest Glen Skill 5. Social Security Number 6. S		ge (In yrs. last i	to instructor ()	Silver If Under 1 Year	Spring	Date of Bird		itgom	
	Funeral Director		577-56-8085	ex □M 2∑ F 7. A		Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day 9/28/3	y, Yea <i>r)</i> 7	9. Birthi	place (State or Foreign ntry) N • C •
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	Maryl f sho	5	DC				on, DC					1X Yes 2 □ No
	28a-	Director	10e. Street and Number		Wasii	iriigt	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	death with the Maryland rms 23a or 28a-f show r must be notified at	<u>e</u>	2406 - 3rd Stree	t, N. E.			2000	2		USA		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. V	Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-			can Indian,
20	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene item 23 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, I're Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2.\(\tilde{\Lambda}\) If Yes, Give Year or Dates:	No		Yes 21 No	Specify:	rican, etc.)		ck, White, y: Bla	
200-	s filed within 72 hours il Hygiene. other than "natural", rent, the Wedical Ex-		15. Decedent's Ed	lucation		Sa. Deced	ent's Usual Occup	ation		16b. Kind of B	usiness/In	ndustry
7	hin 7	Completed	(Specify only highest gra	de completed) College (1-4or	5+)	life. L	kind of work done of NOT use retired	ation during most of work t)	ring			
V	filed within Hygiene. Ither than "	Б	Elementary/Secondary (0-12) 9 th			Labo	rer			Self	Emp1c	yed
yland	tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nam	, , , ,	Maiden Suman	ne)	
<u>8</u>	2 should be a and Mental is marked c raumatic eve	ဥ	Sam Norfolk					Iola No				
M	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship () Junious Durham/H	•	2	9b. Mailin 406	g Address (Street - 3rd Sti	and Number or Rui reet, N.E	., DC 20	er, City or Town, 0002	State, Zip	o Code)
ē,	s 1 ar f Hea item		20a. Method of Disposition			of Dispos	sition (Name of natory or other place	m) 14/10	Date T	20c. Location	- City or To	own, State
2	Page ento nt: if ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		3	•	Park Cr	11/10/	NO R	iverda]	Le, M	aryland
Dallino	permit. Pages 1 am Department of Healt Important: if item 2 any injury or other once.		21. Signature of Fun al ervice Licer	isee	1	22	. Name and Addre	ss of Facility				me, Inc.
מ	89789		23a. Part Lenter the disease, or com	Wal	10						ish.,	DC 20001
	Physician and // Medical Examiner sthe paral-transit	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or a. b. Due to (or a. c.	s a consequence	æ vil).	solu.	Corde	Man	la Li	503	Interval Between Onset and Beath
0/0	icate be execul physician and s the burial-trar	dical		d								
O. Box 68	death certif e attending id for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		e of pregnancy 2 ☐ Fetal dea at time of death		Ectopic pregnancy Other (specify)	,			ate of deliver	ery Day Year
ords, r	quires that n signed b	þ	Part II Other significant conditions of	ontributing to death	but not resulting	g in the ur	nderlying cause giv	en in Part I.		obacco use con ⁄es 2 □ No		the cause of death?
, ,	2 5 0	Completed	cerebraila	males.	alle	de	W.		24a. Was autop perfor	rmed?	prior to co death?	opsy findings available ompletion of cause of
<u>0</u>	ian: rtifica stor, p	Bec	25. Was case referred to medical					26. Place of Dea				20.110
_	nysica nis ca direc	To E	examiner?	Hospital: 1 ☐ Inpat	ient 2 ER/	Outpatien	t 3 DOA Oth	er: 4 N sing H	ome 5 Resid	dence 6 Oth	ner (Speci	fy)
	nding Pt th. : After th s funeral		27. Manner ol ath 1 Nural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ury 28b ay Year)	o. Time of Injury	28c. Injur Wor M 1 □	y at k? Yes 2 □ No	28d. Describe h	now injury occur	red	
DIVISION	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of Ir	njury - At home, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Numi vn, State)	ber or Rur	al Route Number,
	ne Hospi n 24 hour ne Funeri sletely fills	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the bes niner: On the basis and manner s	of examination	dge, death and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time,	cause(s) and m date and place,	anner as s and due t	stated. to the cause(s)
	To the To the Comp	Š	29b. Signature and title of certifier	Dy			29c. Licens	e number	/	29d. Date signe	d (Month,	Day, Year)
	(Ac		1 / lunon	1 De	uku	14	00	06 4		4//	42	2006
	5		30. Name and address of person who	completed cause of	death (Item 23a	a) (Type,	Print)					
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3	32. Regts	trar's Signature	M. 16	perte				-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#18,perFh, 254, 4/18/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** APRIL 11,2006 6:15 <u>Stella N. Erhardt</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6/30/17 6. Sex **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 🕱 F Yrs. 215-01-3790 88 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location th and Mental Hygiene. ?? ie marked other then "naturel", or items 23a or 28a-f ehow traumatic event, the Medical Examinar must be notitied at 10d. Inside City Limits 1 ☐ Yes 2 No Director Md Baltimore Parkville the th 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8820 Walther Blvd. Apt. 4503 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Hospital permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event pice. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lipinski Albina Koryto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1485 Ironwood Dr. Denham Spring, LA. Mr. John Nowak / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Holy Rosary Ceme. 4/18/06 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Raterortowskia Tuneral Home P.A. Ruly toda 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the discase, or complications that caused th shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) Examiner ACUTE MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner and Il-transit law requires that the death certificate be executed IRBNARY: GATTERY DISENSE Due to (or as a consequence of): physicien a Physician/Medical use as IF FEMALE: 23c. ff yes, outcome of pregnancy 23d. Date of defivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown õ Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown as been si 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?
Yes 2 has page 21/ No certificete 1 Yes 1 Yes To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifice completely filled in by the funeral director. p 25. Was case referred to medical Be 26. Place of Death (Check only examiner? Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide (s) and manner as stated.

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON 7601 OSLER DRIVE TOWSON MARYLAND 21204 M 31. Date fifed (Month, Day, Year) 32 Registrar's Signature State Registrar

				. 1040	State of Ma	nyland	/ Department			_	_	ic.	
			1 - For State Registrar		State of Mis	irytariu	Certificate		u Men		g. No. 0 0	6	11515
	Dhysisi	on.		Name (First, Middle,	Last)					Date of Death	1	/ear	3. Time of Death
	Physici /Medio		Cele	estina	tagan				4	pril	8 2	006	9:15 11
	Examir	ner	4a. Facility Nan	11 1	give street <i>ând</i> number) INS BAVVÎ (1 10 / 5	wn, or Location of Di	eath	•	4c. County of	Death	
	Funeral		5. Social Secur	ity Number 6	Sex 7. Age	In yrs. las	t birthday) If Under 1		Hrs. 8. D	Date of Birth	Vaar)	Birthpla	ace (State or Foreign
L	Director		2/7-2 Usual Residence	0-4963	1□M 2/AF /	18	Yrs.	ays Hours N	Ju	Month, Day,	1927		yland
	yland sow		10a. State	10b. County		10c. City,	Town or Location					10	d. Inside City Limits
	death with the Maryland ms 23a or 28e-f ehow rinual be notified at	ctor	Marylan	d N	A	B	altimore						1 ⊈Yes 2 No
	vith th	Funeral Director	10e. Street and	Number		, #	538 D 10f. Zip Co	ode .		10	g. Citizen of Wh	at Counti	ry?
	ns 23	erai	11. Marital Stat	WindSo	12. Was Decedent B	Ever in U.S.	13. Was Deceden	of Hispanic Origin?	? (Specify	Yes or No-	14. Race	America	n Indian.
p	or Item			us Married 2□ Marrie	Armed Forces?		If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu	uerto Rica	n, etc.)	Black,	White, e	
3	n 72 hours after death with the Marylan "naturel", or Items 23a or 28e-f ehow sidical Exeminar Distributed at	d by	3 🗆 Widow	ed 4 Divorced	Year or Dates:						Specify:	310	ck
7		Completed		15. Decedent's Specify only highest	grade completed)		16a. Decedent's Usual C (Give kind of work of life. DO NOT use i	lone during most of	working	1	6b. Kind of Busi	ness/Indu	ustry
7	d with	mo;	Elementary/	Secondary (0-12)	College (1-4or 5	+)	Homer	naker			Own	He	ome
	be filed tai Hyg d othe event,	Be	17. Father's Na	me (First, Middle, La	ist)			18. Mother's I	Name (Fir	st, Middle, M	faiden Surname,		
<u> </u>	d Men marke	2	Fred	ta a	C(Type, Print)	11.	19b. Mailing Address (S	IVIai	raa	ret	Key:	S 7:- (2ada)
Z	Ith an Ith an Ith art traur		Mc T	arid	Tackson	skter)	/_ II O M	cauette	o Q		city of Town, S	MA	2120/-
e,	nit. Pages 1 and 2 should be filed within ortainent of Health and Mental Hygiene. ortant: if item 27 is marked other then injury or other traumatic event, the Me.		20a. Method of		Gack Sur	20b. Plac	ce of Disposition (Name setery, crematory or othe	of r place)	Date	2	20c. Location - C	ity or Tow	n, State
	Page ment c ant: if ury or			on 5 ☐ Other (Spe	Removal from State cify)	Kin	9 Memoria	. A ///	15/2	006	Balt	0.1	Nd.
Dal	permit. Pag Department Important: eny injury c		21. Sign there of	of Funeral Service Li	censee O D			ddress of Facility	. Fw	neral	Home,	P.A.	2
			23a. Parti En	ter the distrase, or co	omp icati ms that cause	the death.	Do not enter the mode of	I North	Ave.	Balt spiratory arre	o. Md.	2121	Approximate
	Physician		Immediate Cau	neaπ tainere. List or ise (Final	nly one cause on each lin	θ.		-, 3 ,		, , , , , , , , , , , , , , , , , , , ,			Interval Between Onset and Death
	/Medical		disease or con resulting in dea		a. Due to (or as	MOVIL a conseque	nce of):						acys
	Examiner		Sequentially lis	st conditions.	b. luna	m	etastase	5				Y	nonths
	nsit	Examiner	Sequentially list if any, leading cause. Enter L Cause (Disease that initiated ev	to immediate Inderlying e or injury	Due to (or s	a conseque	nce or):					4	150 C - 110
ń	be execut ician and burial-trar	Ехаг	that initiated ev resulting in dea	ents ith) Last	c. Due to (or as	a conseque	nce of):					0	ver one you
200	e x e	cal			d.								
ŏ	The law requires that the death certifica sie has been signed by the ettending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE:		23c. If yes, outcome	of pro							0.000
0	eath c	cian		t 12 months?	1 Live birth	2 🗌 Fetal de	eath 3 Ectopic preg				23d. Date Mont		y Day Year
į	t the d by the	hysi	1 □ Yes 9 □ Unkn		9□ Unknown			//					
'n	es tha igned be del	by P	Part II. Other si	gnificant condition	s contributing to death bu	ut not resulti	ng in the underlying caus	e given in Part I.					cause of death?
cords,	requir	eted							- ,	1 🗆 Ye	s 2 □ No 3	☐ Proba	bly 4 🗹 Unknown
מ	has b	Completed							-	24a. Was an autopsy perform	/ pri	ere autop: or to com ath?	sy findings available pletion of cause of
114		မ လ	25 Was case of	eferred to medical				26. Place of I		1 Yes 2	№ 0 1	Yes 2	2 □ No
	nysicia nis cert direct	To B	examiner?		Hospital: 1 Inpatie	nt 2 EF	VOutpatient 3 DOA	Other			nce 6 ☐Other	(Specify)	
5 =	ing Ph Viter th uneral		27. Manner of D		28a. Date of Injur (Month, Day	Year) 2	Injury	Injury at Work?	28d.	Describe hor	w injury occurred	1	
	ttendi death stor: /	icati	2 Accide	nt investiga 6 ☐ Could no	t be on Dian of lair	ını - At hom	e, farm, street, factory, o	1 Yes 2 No	201.1	ocation (Str	eet and Number	or Pumi	Pouts Alumbas
\$	efter Direction by	Certification:	4 Homic	de determin	building, etc	. (Specify)	e, lami, street, lactory, o	nce		City or Town,		Or Aurai	House Mussiper,
>	hours hours unere	calc	23s Gertifier (Check only	1 ☐ Certifying	Physician: To the best of caminer: On the basis of	if my knowle	idge, death decumed at t	he time, date and pl	lace, and o	due to the ca	uso(s) and man	rof as sta	tod.
•	To the Hospitel or Attending Physician: within 24 hours elter death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical	one)		and manner sta	ted.		cense number					
	는 플 C S	-	290. Signature	and title of certifier	Pagasal		" -	es - 000		29 //	d. Date signed	Month, D	ay, Year)
			30. Name and	address of person wi	no completed cause of de	eath (Item 2		, -000	19		pril 8,	all	106
			Jonet	Record	MD 444	10 E	stern Av	inac ?	Saltin	NNE	MD	212	24
,	Sta		31. Date filed (Month, Day, Year)	32. Registra	ır's Signatur	Local B		-)		
	Registr	ar	Al	U T 9 700	O Parties.	STATE OF							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** February 20, 2006 9:51 Linda Irene Ford р /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 280 South Prospect Street Washington Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F unk 58 Mar 22, 1947 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow the Medical Examiner count be notified at 1 Tyes 2 No Director MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 280 S. Prospect Street 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk Black, White, etc. hours after 1 Never Married 2 Married ō Specify: white Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. à 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working unk
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 unk Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) i. Peges 1 and 2 should be filed wind ment of Health and Mental Hygien trant: If Item 27 is marked other thailury or other traumatic event. unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 21201 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State injury or Department of important: If any injury or once. '4 □Donation 5 ☑ Other (Specify)in state/ permit. 21. Signature Fruneral Service Licensee Ronald 5. Wade, 22. Name and Address of Facility 1014 State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ector auce 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Smoke inhalation and thermal injuries Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) complicating Arteriosclerotic cardiovascular disease **Physician** /Medical Due to (or as a consequence of). Examiner Seque fiely in conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760, nding physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached Ö 9 Unknown ٦ à been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1X Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed? certificate Yes 2□ No Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 DOther (Specify)at scene 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After victim of accidental Division 5 Pending Injury 1 Natural 2 No within 24 hours after death.

To the Funeral Director: Af 1 TYes investigation 9:45p house fire 2/20/06 2 X Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State 280 S. Prospect St 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ŏ Residence Hospitel Hagerstown, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. February 21, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Ana Rubio, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 3 2006 Registrar

2311123		1 - For State Registrar	State of Maryland		artment of H			giene Reg. No.	06	1517
Physic		Decedent's Name (First, Middle, Last) Anna	Cathe	rine	F	lynn	2. Date of Dea Month ADY 1	ath Day	2006	3. Time of Death 9:15A M
/Med Exam		4a. Facility Name (If not institution, give st 249 Carvel Road				Location of Death			nty of Death e Arun	
Funera Director	_	5. Social Security Number 6. Sex 219-20-4408	7. Age (In yrs. In 78	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Jan 21	y. Year) 1928	9. Birthp Coun Mar	lace (State or Foreign try) y l and
e Maryland a-f ehow	ctor	10a. State 10b. County Maryland Anne Aru	,	, Town or Lo adena	ocation				1	0d. Inside City Limits 1 ☐ Yes 2 🛛 No
with the	Dire	10e. Street and Number 249 Carvel Road			10f. Zip Code	122		10g. Citizen o		try?
is 1 and 2 should be tiled within 72 hours after death with the Maryland Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Madical Examplem minist be notified at	1 by Funeral Director		2. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba		pecify Yes or No o Rican, etc.)	- 14. A	lace - Americ lack, White,	
within 72 his ane.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired NEMAKEY	ation during most of wor l)	kıng		Business/Ind	dustry
permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, the Mance.	To Be Co	17. Father's Name (First, Middle, Last) Howard	Klein		nemaker	18. Mother's Nan	ne (First, Middle, DSephine	Maiden Sum		
and 2 shou and 2 shou salth and M n 27 is mar er traumat		19a. Informant's Name/Relationship (Typ George H Flynn	spouse	24	ng Address (Street : 19 Carvel	Road Pas		-		
ages 1.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donaţion ∮ 5 ☐ Other (Specify)	moval irom state		sition (Name of matory or other place ge Cemete		Date 5/2006	20c. Locatio Elkrid	n - City or To Ge Mar	
permit. P Departme Importan eny Injur		21. Signature of Juneral Service Litense	2/		2. Name and Addres	ne of Equility	callings			
Physician		23a. Part1. Enter the di lease, or complic shock, or heart fail re. List only one Immediate Cause (Final disease or condition resulting in death)	a lons hat caused the death had so on each line.	-		tain Road	Pasade	na_MD_		Approximate Interval Between Onset and Death
the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physicien and mpletely tilled in by the funeral director, pege 2 should be detached for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of the consequence of t	ence of): (jth m	Fi S				
that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3[Ectopic pregnancy Other (specify)				Date of delive Month	r y Day Year
w requires that been signed b	þ	Part II. Other significant conditions cont	nbuting to death but not resu	Ilting in the u	nderlying cause giv	en in Part I.	23e. Did to	/		e cause of death? ably 4 []Unknown
The law requ	Completed	Alkho Sel	notic o	U.Se.	gre-		24a. Was autop perfo 1 \(\text{Yes} \)	rmed?	prior to cor death?	osy findings available inpletion of cause of
sician: The scentificate	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	espital:	ER/Outpatier	nt 3 DOA Oth	26	th (Check only o)ther (C	-1
anding Physath. or: After this	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injun	4 Nulsing 1	28d. Describe h			7
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely tilled in by the tu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	·) 			City or Tou	vn, State)		l Route Number,
n 24 hou he Fune pletely ti	Medical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin-	cian: To the best of my known: On the basis of examinat and manner stated.	wledge, deatl ion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the or rred at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
To the To the Confine	M	29b. Signature and title of certifier	agn		29c. License			29d. Date sig	ned (Month, I	Day, Year) 2/06
Y		30 Name and address of person who con	npleted cause of death (Item	23a) (Type,	WATAIN	COAD,	FASAD	SNA,	MD ?	21/22
S: Regis	tate trar	31. Date filed (Month, Day, Year) APR 1 3 2006	32. Registrar's Signat	ure and	é					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** JUNE GARY - MC HEILL 11:35 B W 11994 200€ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UBJD BURNIE 1304USA3UUA BALTIMORE-WASHINGTON MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F Director 212-48-3765
Usual Residence of Decedent May 21. 1947 Maryland 58 10c. City, Town or Location 10d. Inside City Limits 10a, State Item 27 is marked other than "naturel", or iteme 23a or 28a-f show other treumstic event, ite Midical Exeminar must be notified at 1 ☐ Yes 2 PNo Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 102 Thomas Road 21060 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 PNo δ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/APharmacy Technician Giant Food permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is markad oth any lighty or other treumstic event song injury or other treumstic event 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Reckline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daniel J. McNeill (Husband) 102 Thomas Road Glen Burnie, Maryland 12060 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4/11/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK 2 DAYS /Medical Examiner 2 PAO P PHEUNONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physicien end the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, use as IF FEMALE: 23c. tf yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ COLD 1 X Yes 2 No 3 Probably 4 Unknown page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 KNo 1 Yes 2 No Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Linpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury after deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours at To the Funerel D completely filled in the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier as a con a war. (min as ille D0065114 d cause of death (Item 23a) (Type, Print) 301 HOSPITAL DRIVE, GLEN BURNIE, MD, 210E1 GUILLERMO JOSE ODBABUATO

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death GER. APRIL **Physician** Year: WILMER · K. Z . 30PM 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1934 Pennsylvania **Funeral** 1 M 2 □ F Days Hours Min Months Yrs Director 213-32-3049 71 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show Examiner must be notified at 1 ☐ Yes 2 👿 No Director Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Items 23a 3113 Edgewood Road 21043 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\fomale Yes \) 2 \(\to \) No If \(\fomale S \), Give Year or Dates: \(1962-64 \) Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. tiled within 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White "netural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumatic event, I've Medical 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Healthcare Physician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilmer K. Gallager, Sr. Helen Elizabeth Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tree once. Ann Dodson Gallager, wife 3113 Ed ewood Road Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 04/11/06 Baltimore MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician CEREBRAL BLEED dere disease or condition resulting in death) /Medical **Examiner** COAGULOPATH Sequentially list conditions, any testing to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be execute. physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown ORTERY DISEAST 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an DEMENTIA MULTI INPARCI rmeo. 2⊠ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) P 2 FR/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 🗌 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 30469 APRIL 10, 2006 Name and address of person who completed cause of death (Item 23a) (Type Print) KWAY # 308 COLUMBIA. MD. 21045. B. VELLANKI, 8850, COLUMBIA, 100 MEKWAY # 308 COLUMBIA. MD. 21045.

Registrar

APR 1 3 2006

31. Date filed (Month, Day, Year)



State

			1 - State Registrar	ate of Maryland /		rtment of H		nd Mer		ene g. No.	0.6	1152	0
			Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day	Year	3. Time of De	ath
	Physici /Media		Sally Ann Griffi	n				A	mil	10	2006	1730	М
	Examir	er	4a. Facility Name (If not institution, give street	1	1	4b. City, Town, or	A	Death /		4c. Co	unty of Death		
			UNIVERSITY Special			BACTIN If Under 1 Year		Hro. Lo.					
П	Funeral Director		5. Social Security Nun/ber 6. Sex	7. Age (In yrs. last b	Yrs.	Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	Coun	ace (State or F try) 1 Carol:	
			Usual Residence of Decedent	74					1/17/19	34	NOLLI	Caror.	LIIA
	yland		10a. State 10b. County	10c. City, Tov	wn or Loc	ation					10	d. Inside City I	
	e Ma	ctor	Maryland		Ba1	timore						1 🖾 Yes 2	□ No
	ith th or 28	Directo	10e. Street and Number			10f. Zip Code			10	g. Citizer	of What Coun	try?	
	ath w	ra	118 North Smallwood			1	1223			U.S.			
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23e or 28e-f show event, the Madical Exertil at rotal be natilied at	by Funerai	1 Never Married 2 Married 1	as Decedent Ever in U.S. πed Forces? □Yes 2∛□No Yes, Give ear or Dates:		/as Decedent of H Yes, specify Cuba □ Yes 和 No	ispanic Origin n, Mexican, F Specify:	n? (Specify Puerto Rica	y Yes or No- an, etc.)		Race - America Black, White, e pecify: Blac	etc.	
у О	72 ho	sted	15. Decedent's Education (Specify only highest grade com		a. Deced	ent's Usual Occupa	ation	f working	1	6b. Kind	of Business/Ind	ustry	
2	ithin i	Completed		pilege (1-4or 5+)	life. D	O NOT use retired	iunny most of	i working					
2	s filed within 72 h I Hygiene other then "nati rent, Iro Music	CO	7			Housewi					memaker	<u> </u>	
and and		Be	17. Father's Name (First, Middle, Last) Julius Chavis						irst, Middle, M		mame)		
ž	s 1 and 2 should be if Health and Mental item 27 is marked oother treumatic eve	2							Hartsfi				
<u>8</u>	d 2 sho th and 7 is mu treum	1 1	19a. Informant's Name/Relationship (Type, P			g Address (Street a							
	1 and 2 Health tem 27		Peggie Gilmore / Daug 20a Method of Disposition	20b. Place	of Dispos	Smallwo ition (Name of		eet,	Baltin	Oc. Local	Maryla tion - City or To	ind 2122	23
2	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State cemete	ery, crem	atory or other place natory In							
Baftimore,			21. Signature of Funeral Service Licensee	riecto		Name and Addres							_
ñ	Departr Departr Importe any inju		In John			l Park H						-	
			23a. Part /. Enter the disease, or complication shock, or heart /ailure. List only one cau	ns that caused the death. Do								Approximate Interval Between	
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V.	/Medical		resulting in death)	Due to (or as a consequence	of):	04 (0	(MCIN ON	19 0	& Con	7			
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,	₽ #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):			-					
V	and trans	Examiner	that initiated events c	D									
င္တဲ့	cate be executed oblysician and the burial-transit			Due to (or as a consequence	e or):								
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O. Box	The iaw requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	Physician/Me	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal deat Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)				230	Date of deliver Month	ry Day Yea	ır
1	that the ded by detact	/ Ph	Part II. Dther significant conditions contribut	ing to death but not resulting	in the un	derlying cause give	en in Part I.		23e. Did toba	acco use	contribute to th	e cause of deal	th?
Records,	w requires been sign should be	eted by	Chronic chstuctive			, , ,	<u> </u>	_			lo 3 ☐ Proba		
аі не	0 4	Completed							24a. Was an autopsy perform	No No	4b. Were autor prior to con death?		ilable se of
Vitaí	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospit	al: 1 Inpatient 2 ER/O		aC DOA Othe	ar.		heck onlone				
ō	ding Phys h. After this funeral dir	H- 1		a. Date of Injury 28b.	Time of	3 DOA 28c. Injury	4 🗀 Nursi		. Describe how		Other (Specify coursed)	
DIVISION	ath. r: Afte e fun	atioi	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		<br Yes 2 □No			. ,			
N S	Atte	iffica	3 Suraido 6 Could not be	e. Place of Injury - At home, f	arm, stre	et, factory, office		28f.	Location (Stre	et and N	lumber or Rural	Route Number	τ,
5	tel or rs afte el Dir ed in	Certification:	TOTAL CONTROL OF THE PARTY OF T	building, etc. (Specify)					City or Town,	State)			
	To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: After the completely filled in by the funera	edical	(Check only 2 Medical Examiner: C	To the best of my knowledge In the basis of examination a and manner stated.	ge, death nd/or inve	occurred at the timestigation, in my of	ne, date and pointon, death	place, and occurred a	due to the cau at the time, dat	use(s) an e and pla	d manner as sta ace, and due to	ated. the cause(s)	
	with Com	Σ	29b. Signature and title of certifier			29c. License	3049	4			igned (Month, I	Day, Year)	
			30. Name and address of person who completed. NEH/M USH		(Type, P	rint) hovles 5	reor	Ba	Hurr	e n	10 212.	} 0	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2006	32 degistrar's Signature	1500	40							

			1 - For State Registrar	State of Maryland		nt of Health and te of Death	F	Reg. No. U U U	11521
	Physici	_	1. Decedent's Name (First, Middle, Last) William	Arthur Garl	and		2. Date of Dea Month April 8	Day Year	3. Time of Death 9:00 A
	/Medic Examin	-	4a. Facility Name (If not institution, give si	treet and number)	4b. City	, Town, or Location of Dea	th	4c. County of Death	
4	· · · · · ·	¥ .	Bethesda Health Ca	are and Rehab		Bethesda er 1 Year If Under 24 Hr.	s. 8. Date of Birt	Montgom	ery nplace (State or Foreign
**************************************	Funeral Director		5. Social Security Number 6. Sex 1団	M 2□F 86	Yrs. Months			$y, Y \theta a r)$ Co.	ington, D.C.
- Box	~ o		Usual Residence of Decedent	10c Cib	, Town or Location				10d. Inside City Limits
	ahow	o.	10a. State 10b. County		Chevy C	bess			1⊠Yes 2□No
	28a-f	Director	Maryland Montgome	ry		ip Code		10g. Citizen of What Co	untry?
	h with	al DI	4315 Curtis Road			20815		United S	tates
	deat	Funeral	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	S. 13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race - Ame Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hygiene. Importent: If Itam 27 is marked other than "natural", or itame 23a or 28a-f ahow appriatury or other treumatic avent, the Musical Exercities must be notified at once.	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII	1 ☐ Yes	2⊠ No Specify:		Specify: Wi-	ite
Maryland 21215-0036	2 hour	ted t	15. Decedent's Educ	eation	16a. Decedent's Us	ual Occupation	odina	16b. Kind of Business/	
215	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	rork done during most of w use retired)	DIKING	_	
2	ed wil ygien her th	Con		4	Engi		amo (First Middle	Department Maiden Sumame)	of Defense
and	d be fill notal H ed otl	Be	17. Father's Name (First, Middle, Last) Charles Brown Gar	l and				th Bowles	
Ž	Shoulk nd Me mark mark	2	19a. Informant's Name/Relationship (Typ		19b. Mailing Addres	ss (Street and Number or I			Zip Code)
Ž,	and 2 salth a 27 is er tree		Alice Bird/Dau			is Road, Che			
Baltimore,	of He of He If Itam or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	C	lace of Disposition (Nemetery, crematory or ntoomers. C	ame of other place) Aj rematorium	oril 13	20c. Location - City or	
Ë	t. Pag nment nent: njury o		4 □ Donation 5 □ Other (Specify)	110	Inc.		2006	Bethesda,	
Ba	Depar Impor		21. Signature of Funeral Selvice License	M0143	3 Bethe Bethe	and Address of Facility Ro sda-Chevy Ch sda, Marylan	ase, Inc d 20814-	./7557 Wisc	onsin Avenue
100 100 100	% 134		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on fmmediate Cause (Final	e cause on each line.	h. Do not enter the mo	ode of dying, such as cardi			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Pulmonar Due to (or as a conseq	y Fibrosis				
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99	eath certificat attending phy I for use as the		IF FEMALE.						
Вох	ath ce ttendii or use	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	il death 3 ☐ Ectopic			23d. Date of de Month	livery Day Year
0	that the de led by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of d 9□ Unknown	leath 5□ Other (specпy)			
<u>α</u>	89 5 69	þ	Part II. Other significant conditions con	itributing to death but not res	ulting in the underlying	g cause given in Part I.		tobacco use contribute to	o the cause of death?
Records,	w requir been si should	etec					24a. Was	an 24b. Were a	utopsy findings available
Re	The lay	Completed					auto perfe	ormed? death?	completion of cause of
Vital	10 -	Be C	25. Was case referred to medical examiner?	- 025			eath (Check only		
of V	Physician: this certific ral director,	2	1 ☐ Yes 2 🖾 No	fospital: 1 Inpatient 2				idence 6 Other (Spe	ocify)
	ing After une	lon	27. Manner of Death 1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	26d. Describe	how injury occurred	
Division	deati deati ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact			(Street and Number or R wn, State)	ural Route Number,
	Hospite 4 hours Funerel	Medical Ce	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, death occurrention and/or investigati	ed at the time, date and pla on, in my opinion, death or	ice, and due to the courred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mon	th, Day, Year)
	6 ਜ ≲ ਜ	ì	1 Alpanel	gonami	MD	D27660		4/10/00	/ >
-	1971		30. Name and address of person who	mpleted cause of death (Itel	m 23a) (Type, Print)			1	
	10		Alpana Goswami, M			e, G100, Roc	kville, l	MD 20852	
	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 1 3 20	32 Registrar's Signa	the speeds				

			1 - For State Registrar	State of M	arylan		artmen e <i>rtificat</i>			and Me		jiene eg. No.	006	e company	522
			1. Decedent's Name (First, Middle, Las)						2.	Date of Dea Month	th Day	Year	3. Time o	of Death
	Physici /Medio		William Grau Jr							F	ebruar	y 20	2006	1:32	РМ
	Examir		4a. Facility Name (If not institution, give	street and number))		4b. City,	Town, or	Location o	of Death		4c. Cou	unty of Death		
			114 South Broady	ay			Balt	imor	e			N/A			
	Funeral		5. Social Security Number 6. Se	x 7. Ag ∂M 2□F		last birthda	/) If Under Months	1 Year Days	If Under a	Min.	Date of Birth (Month, Day	, Year)	Coul	place (State ntry)	or Foreign unk
	Director			QM 2UP	81	Yrs.				J	June 23	3 , 192	.4		ulik
	put *		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or	ocation						1.	10d. Inside (City Limits
	anyla	5													s 2 No
	7 9 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	ecte	MD		Bal	timor	e 10f. Zip	Code				IOa Citizaa	of What Cou		
	or Den	급	10e. Street and Number									log. Citizen		itu y r	
	a 23	by Funeral Director	114 S. Broadway	Room 7	- Consin II	6 10		224		ain? /Canai	v Voc or No	14.1	USA Race - Americ	can Indian	
	er de Item	un.	11. Marital Status unk	12. Was Decedent Armed Forces: 1 Yes 2	? 11	nk	If Yes, specific	cify Cubai	n, Mexican	n, Puerto Ric	y Yes or No- can, etc.)	14.1	Black, White,		
36	rs aft	JY F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	NO		1 🗆 Yes	2 X No	Specify:			Spe	ecify: whi	tο	
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or itema 23e or 28e-f ahow ta Modeal Exerciner maal be notified at	pa	15. Decedent's Ed			16a. Dec	edent's Usua	al Occupa	ıtion			16b. Kind o	of Business/In		
15	in 72	Completed	(Specify only highest grad	le completed)		(Gir life	e kind of wo DO NOT u	rk done d se retired,	luring most	t of working	unk			ur	nk
12	filed withi Hygiene. other than	E O	Elementary/Secondary (0-12) unk	College (1-4or 1nk	5+)										
	be illed within 72 hours after deeth with the Marylan stal Hygiene. ed other than "natural", or itema 23e or 28e-f ahow event, the Medical Exterioret meal be resilitied at	0	17. Father's Name (First, Middle, Last)				ur	k	18. Mothe	er's Name (F	First, Middle,	Maiden Sun	name)	un	k
lan	Mental Mental arked c	To B					u.							GII	K
Maryland	permit. Pages 1 and 2 should be filled within Department of Heelih and Menial Hygiene. Important: if Item 27 is marked other then any injury or other traumatic event, ITEM ODGE.		19a. Informant's Name/Relationship (7	ype, Print)		19b. Ma	iling Address	(Street a	nd Numbe	er or Rural R	Route Numbe	r, City or To	wn, State, Zip	o Code)	
	and 2 selith a n 27 is		O.C.M.E.			111	Penn S	Stree	t Bal	ltimor	e, MD	21201			
ē,	S 1 a		20a. Method of Disposition		1 ^	lace of Dis	position (Nar ematory or c	ne of other place	9)	Date	9	20c. Locati	on - City or To	own, State	
9	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☒ Other (Specify		9		omalory or o		1						
Baltimore,	permit. I Departm Importa any inju		21. Signature of Funeral Service Licens	100			22. Name ar	d Addres	s of Facilit	ty					
ä	F G F F G		Ronald S. W	ade, byre	etor		state . Saltimo	Anato	omy B	oard 6	555 W.	Balti	imore :	Streat	
1	-6-74		23a. Part1. Snter the diseas or mp shock, heart failure. List only	lications that cause	d the death						espiratory arr	est,		Approxima Interval Be	
	Physician		Immediate Cause (Final	Arteri		rotic	card	i 05726	ecula:	r die	2250			Onset and	Death
	/Medical		disease or condition resulting in death)	aDue to (or as			our u.	LOVA	oura.	1 4150	Lasc			<u></u>	
	Examiner			_									}		
		Jer	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a व व्यावकर्षी	uence of).									
	outed Id ransit	Examiner	inal initiated events	c.											
oʻ	an ar rial-t	EX	resulting in death) Last	Due to (or as	s a consequ	uence of):									
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Icai		d											
9	diffica ng ph as th	Med	IS SEMALE							-		passo			
Вох	eath certific attending p	an/A	23b. was decedent pregnant	23c. If yes, outcome 1☐Live birth			B⊟Ectopic pi	regnancy				23d.	Date of deliv		Vans
. E	the att	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (sp						Month	Day	Year
P.0	that the deed by the detached	h.	9 ☐ Unknown					_					. 14		
Ś	res tha igned be del	by	Part II. Other significant conditions co	intributing to death I	but not res	ulting in the	underlying o	ause give	n in Part I.			_	contribute to t		
ord	w requir been si should										101	es 2□N	o 3 Proi	bably 4x	JUNKNOWN
Records,	has be	Completed									24a. Was a autop	sv	4b. Were auto	opsy findings impletion of	s available cause of
Œ	The ate h page	NO.									perfor	med?	death?	2 □ No	
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death (0	Check only or	10)			
>	A S	10	1 ☑ Yes 2 □ No	Hospital: 1 Inpati	ient 2 🗆	ER/Outpat	ent 3 DC	OA Othe	ar: 4 □ Nu	rsing Home	5 🗌 Resid	ence 6 🔽	Other (Speci	y)Scen	e
			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time Injun	of 2	28c. Injury Work	at	280	d. Describe h	ow injury oc	curred		
<u> </u>	Attending r death. ector: Atte	atic	2 Accident investigation				М	101	/es 2 🔲	No					
Division	i or Attendi after death. Director: A I in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of III	njury - At ho	ome, farm,	street, factor	y, office		281	Location (S City or Tow		umber or Run	al Route Nu	mber,
	itel or rs afte al Dir	Cer							SVE	9. l	100	11			
	To the Hospitel or Attence within 24 hours after death To the Funeral Director: completely filled in by the	cai		sician: To the best											(s)
	the Pin 24	Medical	one)	and manner s											
	To T	2	29b. Signature and title of certifier	1	//		29	c. License	number		2	290. Date si	igned (Month,	uay, Year)	
			1 UNI	1/6		~		OCME			F	ebruar	cy 21,	2006	
			30. Name and address / person who d	completed cause of	death (Item	n 23a) (Typ									
			Ana Rubio, M.D.	100				enn S	Stree	t Bal	timore	, Mary	yland 2	21201	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 3 2008	32. Regist	trar s Signa	ture	W.								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Neva E. Goldthorpe Apr 3. 2006 4:15 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Wilson Health Care Gaithersburg Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Yrs. Director 579-14-1847 Feb 1, 1905 TX Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d, Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinations the motified at 1 ☐ Yes 2√ No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 511 20877 401 Russell Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No by Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7/ h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) unk unk Secretary US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theo Lacy Edmiston Ruby Juanita Yowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is rr any injury or other traum once. Donna Self/daughter 11210 Silversmith Lane Fredericksburg, VA 22407 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4
Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Romild S. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Wade man Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 3 Probably 4 Unknown 2 No 1 ☐ Yes page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No Division of Vital 1 Yes 1 ☐ Yes the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 2 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funaral Direct 4 | Homicide **Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of pirron who completed cause of death (Ity 23a) (Type, Print) cause of death (ILV) 23a) (Type, Print)

NO. 18016EORGIA AVE, SUITE DOT SILVEN SPLINC

18. Registrar's Signature

NO 20902 MERLYN VENURY 42. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar APR 1 3 2006

		1	For State Registrar	State of Ma	aryland		ırtment <i>tificate</i>			nd Me		iene _{eg. No.} 000		1524
	Physicia	an	1. Decedent's Name (First, Middle	Last) 11berg Gloc	kler						2. Date of Dea Month April	_	Year	3. Time of Death 7:25 P. M
	/Medic Examin		4a. Facility Name (If not institution Calvert Memoria	give street and number) al Hospital					Location of Frede			4c. County o		
	Funeral Director	- 1	5. Social Security Number 718–14–9545	6. Sex 7. Age 1	e (In yrs. Ia 90	st birthday) Yrs.	If Under Months		If Under 2 Hours	Min	8. Date of Birth (Month, Day Sept • 7	Year)	Coun	ace (State or Foreign try) Chusetts
	aryland show		Usual Residence of Decedent 10a. State 10b. County Maryland Calve	ert.		, Town or Lo	cation						10	Od. Inside City Limits
	with the M a or 28a-f be notified	Directo	10e. Street and Number 50 Appeal Lane				10f. Zip	Code 2065	57		1	10g. Citizen of Wi		
36	should be filed within 72 hours after death with the Maryland of Menal Hygiene. The Hygiene marked other than "neturel", or Items 23a or 28a-f show marked other than "neturel", or Items 23a or 28a-f show matic event, it a Medical Examinating fluid the motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1	No		Was Deced f Yes, spec			in? (Spec , Puerto F	cify Yes or No- tican, etc.)	14. Race Black Specify:	, White,	
Maryland 21215-0036	within 72 houiene. iene. than "neture it e Medical E	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5	5+)	(Give lite.	dent's Usua kind of wor DO NOT us S/Serv	rk done d se retired	during most	of workin	g	Railroa		dustry
		To Be C	17. Father's Name (First, Middle, Otto Gottlieb (,						(First, Middle, Florent	Maiden Sumame tia Hal) 1ber	9
Mary	nd 2 shou alth and N 27 Is mai		19a. Informant's Name/Relations Sandra Lee Keys						Repu			r, City or Town, S 1626		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menia Important: If item 27 Is marked any injury or other traumatic ev once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Other (S		Geo Med	ace of Dispo met Wasi ical (enter	rers c				Washingt	ton,	D.C.
Balti	permit. Departn Importa any inju		2 Signature of Juneral Service	Oleds]]	P.O. I	Box	58007	Wasl	nington	ortuary , D.C. 2		7
Y.	Physician /Medical		23a. Pan1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause on each limit a. BLASS Due to (or ass							r respiratory ar	rest,		Approximate Interval Between Onset and Death
760,	physicien and physicien and sthe burial-transit	lical Examiner	Sepantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as d.	a consequ	инисе of).		916	VE.					
O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	□Ectopic pr □ Other (sp		′			23d. Date Mor		ery Day Year
ds, P.O.	uires that the signed by Id be detacted	d by Ph	Part II. Other significant condition	ON.	AYI	2072							ibute to t	he cause of death?
Recor	The law require ate has been si page 2 should I	Completed	ROOR NOTE CELLULITIS	CIDONAL	SMA	HUS.					24a. Was autor perfo	osy ormed2	Vere auto prior to co leath? Yes	opsy findings available impletion of cause of
Vita	ician: certific rector.	To Be	25. Was case referred to medical examiner?	Hospitaf:	ient 2 🗆	ER/Outpatie	int 3 D0	Oth	000		n <i>(Check only o</i>	one) dence 6 □Othe	er (Speci	(y)
Division of Vital Records,	tending leath. tor: After the fune	Certification:	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of fr	ay Year)	28b. Time of Injury	М		ryat rk? Yes 2 □	No				al Route Number,
۵	Hospital 4 hours Funeral ely filled	ledical Cer	29a. Certifier 1 Certifyi (Check only 2 Medica	ing Physician: To the bes I Examiner: On the basis and manner s	of examina	wledge, dea tion and/or i	th occurred	at the ti	me, date ar opinion, dea	nd place, a	and due to the ed at the time,	cause(s) and ma date and place, a	inner as s and due t	stated. to the cause(s)
R	To the within 2 To the complet	Med	29b. Signature and title of certifit	Sideligge				De	se number				+16,	16.
			30. Name and address of person	who completed cause of	death (Item	n 23a) (Type	Print)	P	RINC	E \$	PEDGE (X 1663	Sold	CS HD 78
*	St Regist	ate trar	31. Date filed (Month, Day, Yea, APR 1	2006 32 (egis	trar's Signa	ature	Sink	,						

			1 - For State Registrar	State o	f Maryland		artment <i>rtificate</i>			and M	lental Hy	giene Reg. No.	006		11525
			1. Decedent's Name (First, Middle	e, Last)							2. Date of De	ath	Vas	,	3. Time of Death
i	Physicia /Medic		Rosie			Gibb	s				April	11 ^{pay}	200	6	5:05P M
ì	Examin		4a. Fecility Name (If not institution						Location of	of Death			County of De		J_1
			Anne Arundel 5. Social Security Number		enter 7. Age (In yrs. Ii	ast hirthday)	Anna If Under 1		S If Under:	24 Hrs.	8. Date of Bir		nne Ar		
	Funeral Director		218-48-0803	1 ☐ M 2 ☐ F	60	Yrs.		Days	Hours	Min.	June	2 Year)	945	Gounti Mar	ace (State or Foreign ry) "Yland
	D.		Usual Residence of Decedent					1							
	arylar ehow	<u>_</u>	10a. State 10b. County			, Town or Lo	cation							10	d. Inside City Limits 1 ☐ Yes 2 🖾 No
	the M	Director	Maryland Anne	<u>Arundel</u>	Lot	hian	10f. Zip (ode				10a Citiz	en of Whal	Countr	
	with Sa or	ā	120 Patuxent N	Mohile Est	ate		101. Zip (207	711			US US		0041111	y 1
	death	Funerai	11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13.	Was Decede			gin? (Spe	ecify Yes or No Rican, etc.)		4. Race - Ar		
200	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other then "natural", or items 23e or 28e-f ehow imatic event, I'm Medical Evan her must be rotified at	Ď	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Gin Year or D	2 [X] No ∕e		r Yes, specr 1 ☐ Yes 2		Specify:	i, Pueno	Hican, etc.)		Black, Wi Specify: W		
ה ה	72 ho natur	Completed	15. Decedent	s Education		(Give	dent's Usual kind of work	done d	uring most	t of worki	ng	16b. Kin	d of Busines	ss/Indu	ıstry
7	vithin ne. hen.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use	retired))					т.,	
V	filed with Hygiene. Ither the	ပိ	12 17. Father's Name (First, Middle,	Last)		CIE	rical		18. Mothe	r's Name	(First, Middle			ır	reasurey
0		To Be	Anson S		Gibbs				Ne	ellie	9	111200000	Walk	mar	1
ב כ		-	19a. Informant's Name/Relations								I Route Numb			, Zip (Code)
Ž	and 2 salth a n 27 is er trei		Calvin W. Gibb	os brot	her	2	212 Oa	k Dr	ive I	Pasad	dena MD	2112	22		
ב כ	of He		20a. Method of Disposition 1 □ Surial 2 □ Cremation	3 □Removal from	State	lace of Dispo emetery, cren	natory or oth	er place			Date		ation - City		
	Pa		'4 □Donation 5 □ Other (S	pecify)) G1	en Hav					/2006				Maryland
ם	permit. Departr Importe any inje		21. Signature of Funeral Service	Xh (<u>f</u>		3111 M	<u>ount</u>	ain	Road		lena 1	ral Ho 1D 211	meP 22	'.A.
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of only one cause on e	aused the deeth	. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory a	rrest,		1	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Phy	an bat	-	hva	2 /20	cyto	pen	cc	Tur	pura		
	Examiner		,	Due to	(or as a consequ	ience of):			I	\			`		
Ļ		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a consequ	ence of):								+-	
	cuted	Examin	that initiated events	C											
Ď,	e exe ian ar urial-t	Ex	resulting in death) Last	Due to (or as a consequence of):											
0	icate be executed physician and s the burial-transit	dicai		d										-	
מ אמם	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	1F FEMALE: 23b. Was decedent pregnant in the past 1g months?	1 Live b	tcome of pregnal birth 2 Tetal liant at time of de	death 3	Ectopic pre					2:	3d. Date of o		y Day Year
į	t the de by the ached	hysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unkn			1 Other (ape	City)							
ords, r	uires tha signed I	þ	Part II. Other significant condition	ons contributing to de	eath but not resu	ulting in the u	nderlying ca	use give	n in Part I.		23e. Did			to the Proba	e cause of death?
	e law red has beer le 2 shou	Completed									24a. Was		24b. Were prior t	o com	sy findings available ipletion of cause of
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<u>=</u>	s certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	spatient 2 1	ER/Outpatien	t 3 DO	Othe	r.		n <i>(Check only</i> me 5 ☐ Resi		□Other (St	necify)	
5	g Phy er this	-	27. Manner of Death	28a. Date	1	28b. Time of Injury		c. Injury Work	*********		28d. Describe			Journy)	
5	andin path. pr: Aft	atio	1	gation	in, bay roar,	mjary	М		res 2 🗆 1	No					
	al or Att	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	innel ZBB, Place	of Injury - At hoing, etc. (Specify	me, farm, str	eet, factory,	office			28f. Location (City or To	Street and wn, State)	Number or	Rural	Route Number,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	edical C		g Physician: To the Exeminer: On the b and man											
	To the within To the comple	Me	29b. Signature and title of certifie	11	M	0	29c.	License	number	8	7	29d. Date	signed (Mo	nth, D	ay, Year)
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			31. Date filed (Month, Day, Year)	10	legistrar's Signat	ture A	nal	7+-	nde	1 1	led.	cal	C 40 M	1	62
	Sta Registr			2006	legistrar's Signat	ASSO	de l'								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:30 PM ARNETTA B. HART APRIL 10, 2006 /Medical 4b. City, Town, or Locetion of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner RANDALLSTOWN If Under 24 Hrs. | 9 Port BALTIMORE FUTURECARE OLD COURT Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🖫 F 92 MARYLAND 212-18-4945 Director 11/20/1913 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 1X Yes 2 □ No BALTIMORE CITY Director MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Peges 1 end 2 should be filed within 72 hours after death with 1 nent of Health end Mental Hygiene. Int: If Item 27 is marked other then *natural', or Items 23a or ? 21207 USA 3704 HILLSDALE ROAD Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 3€No Specify: Specify: BLACK 3 ₩idowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) BALTIMORE CITY Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS CUSTODIAN 9TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ODESSA COPPEDGE JAMES CLAIRBORNE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health e Important: If Item 27 Is any Injury or other trains 3704 HILLSDALE ROAD, BALTIMORE, MD 21207 BARBARA BROWN DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/06 BALTIMORE CO., MD ARBUTUS MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Howell Funeral Home 21207 21. Signature of Funeral Service Licenses 4600 Liberty Heights Ave, Baltimore, MD Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that caused the death, or heart ailure. List only one cause on each line. Physician Impediate Cause (Final disease or condition resulting in death) /Medical Examiner Completed by Physician/Medical Examiner the buriel-trensit Physician: The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last natory of Afry Due to (or as a consequence of): of Vital Records, P.O. Box 68760, 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2D No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of or Attending 5 Pending investigation 1 Natural 2 Accident 1 Tes 2 No death. Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division

State Registrar

DHMH 16 Rev 6/95

within 24 hours

29a. Certifier

29b. Signature and title of certifie

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

- Molling Crownsod RIOL Copseyllogers.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2150 PM 2006 Elizabeth H. Hisky April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore N/A St agnes
Social Security Number Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 💢 F Months Days Hours Yrs. 216-34-2586 70 1935 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Marvland Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 62 Duck Cove Circle 21811 Iteme 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 and 2 should be filed within 72 hours after c Health and Mental Hygiene. em 27 ie marked other then "naturel", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Harmon Hazel Upton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health an, important: if item 27 ie m. eny injury or other. Husband 62 Duck Cove Circle Berlin, Maryland 21811 Thomas M. Hisky, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 04/12/06 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee

Inomas Gregori ²² Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Digith Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) the ? 1 Yes 2 WHO 9 Unknown à Part II. Other significant conditions contrighting to death but not resulting in the unduritying cause on in Rart I. 23e. Did tobacco use contribute to the cause of death? δ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 1□ Yes 2000 Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ № 1 2 atient 2 ER/Outgatient 3 DOA After this funeral 28c. Injury at Work? 27. Manner of Peath 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Lumural 5 Pending 1 ☐ Yes 2 ☐ No М death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 124 hours after d 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 900 cator

32. Registrar's Signature

Print)

30. Name and address of person who completed cause of death (Item 23a) (Type

rwor

31. Date filed (Month, Day, Year)

AR THERE	Death
AR THERE	06 1600 PM
Examiner 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of It RANDALL STOWN CANDALL ST	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 91 Yrs. Months Days Hours Min. 04 0.03, Year 91 Yrs. 1 1 M 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	. 0 -
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	S. CAROLINA
Usual Residence of Decedent	S. CAROLINA
5 > 100 Class 100 Courts 100 City Town 100 C	10d. Inside City Limits
BALTIMORE GWYNN OAK	1 ☐ Yes ZX No
MD BALTIMORE GWYNN OAK 106. Street and Number 107. Zip Code 108. Citizen of Wha	at Country?
SOUVILLIA NOVA ROAD 2 1 2 0 7 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 34 No	American Indian, White, etc.
o = 5	BLACK
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20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1	
MD NATL MÉM. PARK 4/15/06 LAUREL	·
20a. Method of Disposition Second Comparison Compa	OME 21207 TIMORE, MD
23a. PAN. Enter the disease, or complications that clused the death Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Immediate Jause (Final	Onset and Death
/Medical resulting in death) Due to (or as a consequency of):	- cays
Examiner Sequentially list conditions b. Lupu anticoaqulants	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
d. Comparison of the compar	
The past 12 months? 1	of delivery
The past 12 months? Comparison Comparis	,
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There 2 Ino 31 There is a second of the sec	re autopsy findings available
y s s s s s s s s s s s s s s s s s s s	or to completion of cause of the lath? I Yes 22 No
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25. Was case referred to medical examiner? 1	(Specify)
2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 XSNatural 5 Pending (Mon	
O C Accident investigation M 1 Yes 2 No	
28d. Describe how injury occurred Sample Sa	or Rural Route Number,
Ce Ce Ce	
To Wise Time I Dua Continue (IA) Continue Dhysisian To the heat of an Consulation of the Continue Cont	er as stated. I due to the cause(s)
29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.	
The control of the date and place, and the date and place and place and the date and place and pla	Wonth, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	8, 2006
D0059736 April 8	8, 2006

Amend item#1,perM1,854,4718/6 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)

Ceraldine F. Hartline

Geridine F. Hartline 2. Date of Death 3. Time of Death 2006 558 Month **Physician** 0 April /Medical 49. Facility Name ((Linot institution, give stragt and number) CAL CENTER 45. City, Town, or Location of Death SALTIMORE WASHINGTON WED) CAL CENTER 45. City, Town, or Location of Death SALTIMORE WASHINGTON DEVICE GLEN BURN IE 4c. County of Death Examiner ANNE AR WOLL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 ☐ M 2 🔀 F Months Hours 86 212-07-1691 Director 26, 1920 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours after death with the Marylar II hygiene II have contact than "natural", or flams 23a or 28a-f ahow other than "natural", or flams and the motified at 1 ☐ Yes ※XXNo Glen Burnie Anne Arundel Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21061 1015 Phillip Drive Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXX No Specify: White þ Specify: 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 years n/a Homemaker s 1 and 2 should be filed f Health and Mental Hygis fam 27 is marked other other traumatic event, ill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alverdia Miles Thomas B. Medicus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Phillip Drive Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at Important: If Itam 27 is any injury or other traugnos. Thomasine N. McLucas (daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-14-2006 Cedar Hill Cemetery Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A. 21. Sign were of Funeral Service Licensee J. Wayne Osterling 3204 Mountain Road Pasadena, Maryland 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) temorració **Physician** 2 week /Medical Examiner recus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ Hypertensin 1 Yes 2 No 3 Probably 4 Unknown certificete has been si rector, page 2 should Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this After thi 27. Manner of Death 28a. Cate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending s efter de-rai Director: Atr 1 ☐ Yes 2 ☐ No M 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours eff
To the Funeral Di
completely filled in 29a. Certifier Excertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Attonotion 29d. Date signed (Month, Day, Year) 29b. Signature and the Certifier 29c. License number AIDVIL 44973 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 HOSPITAL DRIVE 202, GCENBURNEE MD 21061 GURMEET-S. SAWHNEY MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#8,17,perf H 0854,4/18/06 TT Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** APRIL 2:45 11,2006 MARY Ε. HYSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth4 20 1932 | Birthplace (State or Foreign Months Days Hours Min. | Month, Day, Lear 1932 | Birthplace (State or Foreign Month, Day, Lear 1932 | Birthplace (State or Foreign Month) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F 212-30-1944 April 11,1952 Maryland Director 73 Usual Residence of Decedent daath with tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "naturel", or Iteme 23s or 28s-f show The Medical Examiner must be notified at N/A Maryland Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1441 Battery Avenue 21230 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status parmit. Pagas 1 and 2 should be filad within 72 hours aftar c. Dapartment of Haalth and Mantal Hygiana. Important: If them 27 is marked other than "naturel", or them eny injury or other traumatic event, the Madient sections. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Baltimore, Maryland 21215-0036 Yes Give Specify If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William ٥ Mary McNeir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 436 Madingley Road, Linthicum, Maryland 21090 Kathleen M. Catterton (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 04-15-06 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home 130 E. Fort Avenue, Baltimore, Home P.A. Maryland 21230 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only on cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death **Physician** END STAGE CHRONIC OBSTRUCTIVE resulting in death) /Medical Due to (or as a consequence of): Examiner PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law raquiras that the death cartificate be executed usa as tha burial-transit tha attanding physician and had for usa as tha burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should ba 1 Yes 3 Probably 4 Unknown 2 No Completed baan s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has paga 2 autopsy performed? 2 No cartificata 1 🗆 Yes 200 1 Yes Attending Physicien: diractor. Be 25. Was case referred to medical examiner? 26. Place of Death Check only or Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3 DOA 27. Manner of Peath 1 Natural 2 Accident complately filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No daath. within 24 hours after daa! To the Funerel Director: 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 06 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

BOON P.

31. Date filed (Month, Day,

IM.

M. D

2006

TOWSON MARYLAND 21204

76 OSLER
32 Segistrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month. Year ri 2006 mes 4b. City, Town, or Location 4c. County of Death n of Death Fecility Neme (If not institution, give street end number) Balto Elder GRNESIS Lare If Under 24 Hrs. 8. Date of Birth (Month, Day, Yee Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. lest birthday) 5. Social Security Number Months Days Hours 1**X**M 2□ F Yrs 28-212 - 42 - 3232 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a Stete 1 XYes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21212 rose 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 1 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Business Elementary/Secondary (0-12) College (1-4or 5+) en cing abore Ν 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Lest) trederick City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rurel Route Number 19a. Informant's Name/Relationship (Type, Print) palo. 3434 ied mon Kosalee 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or as a consequence of) resulting in death) Lest 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 1 TYes 2 000 1 Tes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Peges 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Heelth end Mental Hygiene.

Baltimore, Maryland 21215-0020

th end Mental Hygiene. 7 is marked other than "natural", or items 23a or 28e-f sho traumatic event, the Madical Examiner must be notified at

by Funeral Director

Completed

To the Hospital or Attending within 24 hours effer deeth.

To the Funerel Director: After this certificate has been signed by the at completely filled in by the funeral director, page 2 should be deteched it

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Be Completed by

Physician/Medical Examiner Medical Certification: To

State Registrar 25. Was case referred to medical examiner? 200 1 ☐ Yes 27. Menner of Death 1 Artural 2 Accident 5 Pending investigation 3 Suicide

4 - Homicide

29a. Certifier (Check only one)

29b. Signature

Hospital: 1 ☐ Inpatient 6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

3□ DOA 2 ER/Outpalient 28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tyes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other: 45 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

26. Place of Deeth (Check only one)

29d. Date signed (Month, Day, 200

son the completed cause of death (Item 23e) (Type, Plint) 31. Date filed (Month, Day, Year)

32. Redistiar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Maybri1 9 2000 5:40 Pm **Physician** Chance Emmanuel Henry /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 □ F Days Hours Director None 04/06/2006 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Mudical Examinational Le notified at 1 ☐ Yes 2 No Director MD Baltimore Pikesville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 Mt. Wilson Lane 21208 Funerai USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 0 Infant Infant permit. Pages I and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence W. Henry Shanell Colclough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G.B.M.C. PATHOLOW 6701 NICHARLEY Towson m. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Oc. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 587 eu /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 **Z** No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has all director, page 2 s 1☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1.XNatural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D DIWAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 N. Charles Street, Suite 710, Balto MD 21204 Marwan Haji, 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State APR 13 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 2:00 PM April 6, Charlotte H. Fritz Hone /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Sandy Spring Montgomery Brooke Grove Rehab and Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) June 25, 1919 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Hours Min 1□M 2X F 86 Pennsylvania 200-12-2872 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic evant, Ita Medical Examiner must be nutified at 1 ☐ Yes 2 No Maryland 01ney Directo Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20832 United States 17409 Cherokee Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Beauty Shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Hetrick Charles Fritz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9586 Pondera Drive, N.W., Massillon, Ohio Jack Hone / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition April 11, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Apollo, Pennsylvania Riverview Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01420 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HOUSES ASPIRATION AIRMONIA Due to (or as a consequence of): Examiner MENTHS LOVSPAAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): YEARS DEMENTIA SENILE Physician/Medical Due to (or as a consequence of) 23b. Dld tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2**X** No 1 ☐ Yes 2 ☐ No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed the burial-transit and Division of Vital Records, P.O. Box 68760. signed by the attending physician d be detached for use as the buria certificate has al or Attanding Physician: T s after death. i Diractor: After this certificat

with the Maryland

Saltimore, Maryland 21215-0020

edical Certification: To

2 Accident

3 Suicide

29a, Certifier

4 - Homicide

(Check only one)

TED E. HOWE

filled in by the funeral director. 24 hours Hospital

To the Hosp within 24 hou To the Funel completely fil

Registrar

29b. Signature and title of certifier

6 Could not be determined

29c. License number

WILLIAMSPORT

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

21795

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. ARTIZAN

31. Date filed (Month, Day, Year) APR 1



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

				State of Manuford / Department of Health and Mantal Husiana
				1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death
		Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1. Decedent's Name (First, Middle, Last)
		/Medi	cal	WILLIAM JENNINGS, JR. April 8 2006 12:53 PM
		Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGES
		Funeral	47	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	i.	Director		241 80 8793 XXM 2 F 58 Yrs. Months Days Hours Min. (Month, Day, Year) APR. 24, 1947 NORTH CAROLINA Usual Residence of Decedent
		how		10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits
15		within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show than Mudical Exp. ill er f. als be mullied at	Funeral Director	MD PRINCE GEORGES LANHAM XX Yes 2□No
Tennings		vith th	Dire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
6		s 23s	ra	9525 SYLVAN STILL ROAD #A 20723 UNITED STATES
Ê		or items	nu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
en	38	ours after de ai', or items Expourer to	by F	3 □ Widowed XXDivorced 1968 1 □ Yes XX No Specify: Specify: BLACK
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	Maryland 2121			12TH FACILITIES SUPERVISOR LASON MIDATLANTIC
	and	m - 0 5	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
	Ž	should ind Men marke umatic	2	WILLIAM HENRY JENNINGS, SR. DESSIE MAE ALLISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	S S	th and 2 s		TRINA DIETTE MURPHY / DAUGHTER 4522 BALTO WAY ACWORTH, GA 30101
<u>E</u>	ē,	f Healthem	1 3	20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
110	Ë	Pages nent of int: if it		XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND NATIONAL CEM. 04/15/2006 LAUREL, MD
Nilliam	Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: if Item 27 is marked any Injury or other traumatic as 2008.		21. Signature of Fune and Address of Facility MARSHALL S FUNERAL HOME OF MARYLAND, INC.
5	<u> </u>	88 = 8		4308 SUITLAND ROAD SUITLAND, MD 20746
				23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
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		/Medical Examiner		resulting in death) Due to (or as a consequence of):
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	oʻ	e be executed /sicien and e burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):
	3760	0 2 0	Icai	d
	9	leath certificate I ettending physi ifor use es the b	Med	IF FEMALE:
	90 0	ath c	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 close birth 2 retail death 3 rectopic pregnancy 23d. Date of delivery Month Day Year
	o	the de	Physician/Medi	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 U
	صِ ا	that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
	Division of Vital Records, P.O. Box 68	w requires that the de been signed by the should be detached	ed by	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown
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	æ	sicien: The law certificate hes b irector, pege 2 s	mo	autopsy prior to completion of cause of performed death? 1
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	S	Attendid death. ctor: A y the fu	Icat	2 Accident investigation 3 Suicide 6 Could not be determined determined attentioned by the determined determined investigation M 1 Yes 2 No Suicide See. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
	Ω	i or Attend after death Director: , d in by the f	Certification:	determined determined determined determined building, etc. (Specify)
		To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled bliector: After this certificate hes been signed by the ettending phy completely filled in by the funeral director, pege 2 should be detached for use es the	Medical C	29a. Certifier (Check only one) Medical Exeminer: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
		o the	Mec	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		F>F0		1 Jay Turkly H, MD DO042684, 4/08/2006
		16		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	_	17		JAY ZWALLY 575 MAIN SIKEET SOITE 351 LAUREL MD 20707
	1	Sta		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAY ZWALLY 575 MAIN STREET SOITE 351 MUREL, MID 2070-7 31. Date filed (Month, Day, Year) APR 1 3 2006
	(), (b)	Registr	ar	WILL TO FOOD LONG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📋 🗓 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death KOPPLEMAN Month **Physician** Year KENNE 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours 215-28-9664 74 Yrs Director March 3,1932 Paltimore MD Usual Residence of Decedent the Maryland 10a. Slale 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural, or items 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at MD n/a 1 ☐ Yes 2 X Xo Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 600 Light Street Apt. 912 21230 TEA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 X es 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Service Bar Owner 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be f and Mental ? Is marked of Peter P. Koppleman Anna E. Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum <u>once.</u> Robert Kopplemen / Brother 1349 Cambria St., Baltimore MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 🗷 Cremation 3 □ Removal from State April 11, Bayview Crematory 4 □Donation 5 □Other (Specify) Baltimore MD 2006 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Physician NKNOW /Medical Due to (or as a consequence of) Examiner STINAL BLEEDING DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 2 No 3 Probably 4 □Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Impatient 2 1 Yes 2 No this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel C To the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

RAGHA'D JALIL

INTERN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



3001 S. HANOVER ST. , BALTIMORE , MD

RES OOI

APRIL, 10, 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 1643 M HOBERT APRIL KIRKPATRICK 11 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. JOHNS HOPKINS BAYVIEW MEDICAL CENTR N/A 8. Date of Birth (Month, Day, Year) March 23, 1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**火** M 2□ F 69 212-34-6552 Director West Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 9 North Bradford St. 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White "naturel" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) Steel Industry Truck Driver 11 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) permit. Peges 1 and 2 should be fill Department of Health and Mental H Importent: If Item 27 is marked out any injury or other traumatic even since. Be Pheobe Hess Dane Kirkpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ester Kirkpatrick / Wife 9 North Bradford St. Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 4-15-2006 4 Donation 5 Other (Specify) Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Michael E. Canapp 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ASCVD **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Tetal death 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icete has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificete has autopsy perform 1 Yes 2 No 1 Yes 2 No Be (funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ■ ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours efter death. To the Funarel Director: After 1 Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Physician D-0061115 4/12/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE BALTIMORE MD HADIN PANTEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

3 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 2006 Eugene Kucera 4 4:30 a.m. /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Heart Home, Inc. Hyattsville, MD Prince George's 6. Sex 1 M 2 □ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Yeer) Deys Months Hours 73 Yrs. Director 579-66-5858 4/11/1933 Geneva, Usuel Residence of Decedent filed within 72 hours after deeth with the Meryland 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 ☐ Yes 2 ☐ No Director Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 121 4th Street NE items 23s by Funeral 20002 USA 14. Race - American Indian, Black, White, etc. 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 5 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "naturel", white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Professor 12 Education 5+ other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fill Dapartment of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic even Jaoostan Peel Joana Von Tardy 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecylia Bartoszewicz/spouse 121 4th Street NE Washington, DC 20002 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Ronald S. W 22. Name and Address of Facility Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 mue Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Pert Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Congestive Heart failure
Due (or as e consequence of): Unknown Examiner Examiner Drahetes mellitus unknown To the Hospital or Attending Physician: The law requires that the death certificate be axecuted for use as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknow 1 ☐ Yes 2 ☐ No 3 Probably Be Completed by Dementia 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Hypertension 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Medical Certification: To 1 ☐ Yes 2 X No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of the funeral place of the funeral completely filled in by the funeral compl 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43121 Chowdhy, mo NURUL CHOWD HURY, MD? 9801 Georgia Ave, # 341; Silver Spring, MD 20902 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 31. Dete filed (Month, Day, Year) 32. Registrer's Signature APR 1 3 2006 Registrar

DHMH 16 Rev 6/95

			For State Registrar	State	of Maryl	and / Dep <i>Ce</i>	artment <i>rtificate</i>			and M		giene	6	1539
	•		Decedent's Name (First, Middle,	Last)							2. Date of Dea Month		Year	3. Time of Death
	Physicia /Medic		REN'A M. KEYES								APRIL	07,	2006	8:45P M
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, T	Town, or	Location of	of Death		4c. Cour	ty of Death	
			1102 DELCASTLE					OWIE					CE GEO	
	Funeral		, , , , , , , , , , , , , , , , , , , ,	5. Sex 1 □ M X X F		yrs. last birthday, Yrs.	If Under 1 Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birth (Month, Da)	(Year)	Coun	lace (State or Foreign
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	land ow		10a. State 10b. County		100	. City, Town or L	ocation						1	0d. Inside City Limits
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and	be filed ntal Hygi ed other event, L	BeC	17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Nam	e (First, Middle,	Maiden Sum	ате)	
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g n	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service L	Maril	00				TLAND		AL HOME	OF MAR LAND,		
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	Physician		shock or heart failure. List of immediate Cause (Final			a ribia a	ANGED							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	-		C LUNG C	ANGER							-
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ň	death e atte d for	icla	in the past 12 months?	4☐Pre	birth 2 gnant at time		_Ectopic pre ☐ Other (spe					1	Month	Day Year
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier XX Certifying (Check only 2 Medical E	Physician: To t xeminer: On the	he best of my basis of exa	knowledge, dea mination and/or i	th occurred a	at the tim	ne, date an pinion, dea	nd place, ath occur	and due to the red at the time.	ause(s) and	manner as s	tated. the cause(s)
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	V		30. Name and address of person v			PROFESSI		PLAC	E I	LANDO	OVER, MI	20785	,	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** ,2006 arrance /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner OSPICE
(In yrs. last birthday) I Under 24 Hrs. Birthplece (State or Foreign If Under 1 Year 8. Date of Birth Month, Day, Social Security Number 6. Sex 7. Age (In yrs. **Funeral** Days Hours Min. 219-40-1156 Vala (1 ☐ M 2 💢 F Director Usual Residence of Decedent 10d, Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Exeminer must be notified at 1 Yes 2 □ No Director Maryland
10e. Street and Number more 10f. Zip Code 10g. Citizen of What Country? 23a or 212 000 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 1 No Specify þ 3 □ Widowed 4 N Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 te marked o (dister) 19b. Mailing Address (Street and Number of Aural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) alto, Md. 2/2/2 evens Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 12006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Picility 21. Signatore of Funeral Service Licenses Balto, N Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fail vie. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 MONTHS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and the for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, β 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performed? 2 🗆 No 2 No 1 TYes 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3∏ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred To the Hospital or Attending Pr within 24 hours effer death. To the Funeral Director: Affer th 27. Manner of Death ical Certification: Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Characteristics and manner as stated.

Characteristics and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signajure and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 4.10.2006 90 30. Name and address of person who complet a cause of death (Item 23a) (Type, Print) SZINIENTAN ST # 20 BALTIMORE MD 21201

State Registrar

DHMH 17 Rev 1/200

KNISHNAN

32. Registrar's Signature

		1 - State Registrar Amend Ite	m #24a Per		partment of h		Reg.	ZIIIIh	3. Time of Death
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n sig	d be						1 Tes	2 □ No 3 □ P	robably 4 Unkr
sw requires s been si	Completed						24a. Was an autopsy	24b. Were a	utopsy findings ava completion of caus
The fav ate has page 2	Eo						performe	ed? death?	s 2 No
en: ' tifica tor, p	0	25. Was case referred to medical				26. Place of Deat	h (Check only one)		
ysici is cel direc	To B	examiner?	Hospitaf:	ient 2 ER/Outpa	itient 3 DOA	ther: 4 🗆 Nursing Ho	me 5 Residen	ice 6 Other (Spe	ecify)
Attending Physicien: The Ir death. ector: After this certificate he by the funeral director, page		27. Manner of Death	28a. Date of Inj (Month, D	ury 28b. Tim		ury at ork?	28d. Describe how	r injury occurred	
Attendir death. ctor: Af y tha fu	atle	2 ☐ Accident investigation				Yes 2 □No			
or Attendential Directorin by t	Certification:	3 Suicide 6 Coufd not l	28e. Place of II	njury - At home, farm atc. <i>(Specify)</i>	street, factory, office	•	28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number
itel or ref D									
To the Hospitel or Attend within 24 hours efter death To the Funerel Director: completely filled in by tha	Medical	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis	of examination and/o					
the the	Med	29b. Signature and title of certifier	and manner s	nated.	29c. Licer	nse number	290	d. Date signed (Mor	nth, Day, Year)
も温を皆			7 no		AU 4	1764355	16701 A	PRIL 10	, 2006
		10-9	MU		/				
Toth within Toth Comp		30. Name and address of person who	ompfeted cause of	death (Item 23a) (Ty	no Drint)				
6	tate	30. Name and address of person who GRAHAM SAYPER 31. Date fifed (Month, Day, Year)	ompfeted cause of 22 S		Pe, Print)	LTMORE,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 26 per verb., G854 0413/06dib Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** AGNES L . LIVELY APRIL 8, 2:15P^M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 110 N. CENTRAL AVE, APT 223 BALTIMORE CITY
7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. APT. 223 Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1□M 2√2F 214-24-6631 79 Yrs. Director 08/23/1926 N. CAROLINA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits worle r 28a-f ehow N/A 1 XYes 2 ☐ No Director BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
ent: If item 27 Ie marked other than "natural", or Iteme 23e or ury or other freumetic event, the Medical Examinar must be 110 N. CENTRAL AVE, APT. 223 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK þ 3 ∑Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER DOMESTIC 8TH17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MEAD MANNING AGNES BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 CARRIE LITTLE / 1820 SPENCE ST., 16. BALTITURE 20c. Location - City or Town, State DAUGHTER APT. Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any njury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/14/06 4 □ Donation 5 □ Other (Specify) ARBUTUS MEM. PK. BALTIMORE CO., MD 21: Signature of purperal Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death To not enter the mode of dying, such as cardiac or respiratory arrest, tmm diate use (Final dise se condition resulting in death) -IVER **Physician** MONTH /Medical Due to (or as a consequence of): Examiner METASTATI ANCREATIC CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Figure that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): ettending physiclan a for use es the buriel-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death signed by the e 5 Other (specify) <u>Р</u> О Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ of Vital Records, TOUSION 3 Probably 4 Unknown this certificate has been si-ral director, page 2 should ! 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2□No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specific 2 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Division .el or At.

Jurs after deav.

I Director: An.

in by the fur. 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation м 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel c within 24 hours af To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 4/11/2006 who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature 31. Date file A Porth, Pay 3 of 106 State Registrar

			1 - For State Registrar	State of Marylar	id / Depa	artment of Health	and Me	•	ne 006	11543
	Physici /Medic		1. Decedent's Name (First, Middle, Last, DAVID	1	_0Y	D		Date of Death Month PRIL	Day Year 7 2006	3. Time of Death 2:00 PM
	Examin	_	4a. Facility Name (If not institution, give	Street and number)		4b. City, Town, or Location BALTI		E	4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Security Number 215.30.3134 Usual Residence of Decedent	7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Year if Under Months Days Hours	s Min.	Date of Birth (Month, Day, Ye	ear) Cou	nplace (State or Foreign untry) WEST VA
	Maryland -f show	tor	10a. State 10b. County MD ANNE ARU		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a with the	I Director	10e. Street and Number 16 CEDAR HILL RD.		22211011	10f. Zip Code 21225		10g.	Citizen of What Con	
920	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hydiene. Importment of Health and Mental Hydiene. Instruction: If the marked other then "natural", or items 23a or 28e-f show eny injury or other traumatic event, the Medical Examinat must be notified at ODGe.	by Funeral		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Clif Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☐ No Specify XX		y Yes or No- can, etc.)	14. Race - Amer Black, White	
1215-0	vithin 72 ho ne. hen "natur e Medicel I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during me DO NOT use retired)	ost of working		b. Kind of Business/l	ndustry
Maryland 21215-0036	ld be filed v ental Hygie ked other t Ic event, In	To Be Co	12 17. Father's Name (First, Middle, Last) NOLAN FRANK LLOYD		L CR			BI First, Middle, Maid		STEEL
, Mary	and 2 shou alth and M 27 ie mar or traumat	-	19a. Informant's Name/Relationship (Ty JEANETTE A. LLOYD	ре, Print) WIFE		ng Address (Street and Num DAR HILL RD.	nber or Rural R	Route Number, Ci	ity or Town, State, Z	ip Code)
Baltimore,	Pages 1 or ment of He ant: If item ury or oth		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crei	sition (Name of natory or other place) L CEMETERY	Date 4.11.2	200	LTIMORE,	
Balt	Depart Depart import eny inj	1	21. Sign a reo Juneral Service Licens K. GREGORY FINK	MO1148	F	2. Name and Address of Fac INK FUNERAL F 26 CRAIN HWY	HOME, P	N BURNTE	E, MD 2106	
760,	Cate be executed Physician and Examiner I the private transit	dicai Examiner	23a. Part 1. Enter the disease or comb shock, or heart failure. Lest only of shock or heart failure. Lest only of shock or condition resulting in death) Sequentially list conditions, the shock of the	Due to (or as a consequence to (or as a consequence)	Uence of):	TRUCTIVE J				Approximate Interval Between Onset and Death
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rds, P	w requires thet been signed b should be dete	þ	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderlying cause given in Par	rt I.	23e. Did tobeco	coluse contribute to	the cause of death? obably 4 []Unknown
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ion of	Attending Physicien: r death. ector: After this cartifice by the funeral director, p	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		280	d. Describe how in	e 6 □Other (Speci injury occurred	пу)
Divis	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)			City or Town, S		
	To the Hospital or Ai within 24 hours after or To the Funerel Directompletely filled in by	Medical	one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, deatl tion and/or in	vestigation, in my opinion, di	leath occurred	at the time, date	and place, and due	to the cause(s)
)	CO CO	-	29b. Signature and title of certifier	MD		29c. License numbe			Date signed (Month	
	10		30. Name and address of person who co	mpleted cause of death (Item	30R	Print) HOSPITAL,	3001	SHO	NOVER .	, 2006 STREET, 1D 21225
3	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2006	32. Registrar's Signa	iture				, , , ,	

			For State Registrar	State of M	Marylan		artment of F rtificate of			Hygiene Reg: No		5
	Physici /Medic		1. Decedent's Name (First, Middle, James	Last)		Lav	m		2. Date Mon	of Death th 9	2006	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, ghostillary Media) 5. Social Security Number 6	cal co	Mey Age (In yrs.		If Under 1 Year Months Days	If Under	24 Hrs. 8. Date	of Birth		thplace (State or Foreign buntry)
(g/y 3	Director Moyou		248-50-8925 Usual Residence of Decedent 10a. State 10b. County	IIAM 2UF	73	Yrs. y, Town or Lo	cation		09/2	7/1932	Sout	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	i 72 hours after death with the Maryland "naturel", or items 23a or 28a-f ehow idical Expaniest must be indiffed at	Direc	Maryland 10e. Street and Number 329 East 28th. S	Street				1218		U	S.A.	
9036	rours after dea rel', or items L'Exeminar m	d by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	If Yes, Give Year or Date	is? XNo		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ※ No	Specify:			14. Race - Ame Black, Whit Specify: B]	te, etc. Lack
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Maryland	should and Men a marke umatic	To Be	17. Father's Name (First, Middle, La Robert Lunn 19a. Informant's Name/Relationship				ng Address (Street	Geo and Number		ack Number, City	or Town, State,	
Baltimore, M	es 1 an of Heal f Item 2 r other	1	Patricia Lee / I 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from Sta	ita C	Place of Dispo emetery, cre	osition (Name of matory or other pla	ice)	Date	20c. l	Location - City or	and 21218 Town, State Maryland
Balti	parmit. Pag Depertment Important: I eny Injury o		21. Signature of Funeral Service Li 23a. Part 1. Enter the disease, or coshock, or heart failure. List or	C:		46	2. Name and Address	ess of Facili Hgts.	yThe Der Ave., B	rick C altimo	. Jones	F/H, P.A. vland 21215
8760,	Physician //Medical Examiner purapple purapp	ical Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequence as a c	uence of): Leop uence of): Leop uence of):	Sepsi vatuy	3	alure			Interval Between Onset and Death Sugar Sug
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Division of Vi	ding Phys After this funeral di	Certification: To B	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investiga 2 Accident 6 Could no determin	t be 28e. Place of	Injury Day Year)	28b. Time of Injury	28c. Inju	iry at ork?]Yes 2 □	28d. Des	scribe how inj	and Number or F	acify) tural Route Number,
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)	3		30. Name and address of person w	h completed u e	BODE Weath (ite Yuc	3a) (Type	D D	107°	44 des 3	81 3aks	ris ?	2006 Pace 0 2002
2	St Regist	ate rar	31. Date liled (Month, Day, Year APR 1	2006	intrar's Signa	afure .	Carles)					

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hysicia			e, Last)								2. Date of D Month	eath Da	V	Year	3. Time of Death
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xamine		4a. Facility Name (If not institution	n, give stre	et and nur	nber)		4b. 0	City, Town, o	r Location	of Death		4c		of Death	
		MERCYMED	ICAL	CE	NTE	ER	B	ALT	MC	RE	MI			A	
neral ector		5. Social Security Number 218-10-5722	6. Sex	217 F	7. Age (In y	rs. last bin	thday) If Ui Yrs. Mon	nder 1 Year iths Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, E Oct. 2	irth 6 , 1	917	9. Birth Cou Mass	place (State or Forentry) AChusetts
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Sea.	ted	15. Deceden	t's Educati	ion		16a.	Decedent's	Usual Occup	ation	t of worki	na	16b. K	Cind of Bu	usiness/Ir	
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any injury		21. Signature of Funeral Service	Licensee	ayne (Oster1				-	k Fu	neral . Ball	Home	, P.	A.	1225
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dical niner	al Examiner	Immediate Cause (final disease or condition	1	Due to	(IEM I	sequence of	of):	mode of dyir	ng, such as	cardiac c	r respiratory	arrest,			Approximate Interval Between Onset and Death
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DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 3 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** LEPPERT JAKY 08-20 M LIGA 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PARK U I //e
It Under 1 Year If Under 24 Hrs.
Months Days Hours Min. OAK CREST CARE CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 220-09-5804 Director April 3, 1920 Maryland 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylai ment of Heatih and Mental Hygiene.
ant: If item 27 is marked other than "natural", or flems 23a or 28a-f show ury or other traumatic event, the Nedical Examinant the notified at Director 1 ☐ Yes 2 X No Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd., apt. 1327 Funeral **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Secretary/Bookkeeper 12 n/a <u>Business</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Bond Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Cynthia Leppert/Daughter 2205 Boxmere Road, Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of tmportant: If any injury or once. 5 Other (Specify) ¹ 4 ☐ Donatio Woodlawn Cemetery 4/14/06 Woodlawn Cemetery 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 21. Signalura Joseph Keliner 10 W. Padonia Road, Timonium, MD Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 0000 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Year 4☐Pregnant at time of death 5 Other (specify) <u>о</u> detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 TNO 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performer 2 No 1 🗌 Yes 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number

Registrar

State

31. Date filed (A)PR

70/01/2

Died

MARY

F800

32. Registrar's Signature

walther Blod

mo

21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			d / Department of Health and	•	_
	1 - State Registrar		Certificate of Death	Reg. No.	
Physician /Medical	Decedent's Name (First, Middle, Las Aa. Facility Name (If not institution, give	Helen 1	May Kows Ci	April Da	3. Time of Death
Examiner	St. Elizabett	, Nursing	Center Balt	imore	NIA
Funeral Director	5. Social Security Number 217-03-613 7 1		last birthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year 4/6/1919	9. Birthplace (State or Fore Country) MD
ma 23a or 28a-f show rmust be notified at neral Director	Usual Residence of Decedent 10a. State 10b. County MD	N/A	y, Town or Location Baltimore City	7	10d. Inside City Lim 1
23s or 28s-f si	10e. Street and Number 1400 Haubert	Street	10f. Zip Code 21230	10g. C	itizen of What Country? USA
ar, or itema xam er m by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 [] Yo If Yes, Give Year or Dates:	.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen 1 ☐ Yes 2XXII o Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
ne then "natural", it. the Medicul Exa Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a. Decedent's Usuaf Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b.	Kind of Business/Industry
or the	8 17. Father's Name (First, Middle, Last)	0	Homemaker 18. Mother's Nat	ne (First, Middle, Maide	Own Home
atic even	Julian Sado		Roza		
27 is marked other then or traumatic event, the Market traumatic event.	19a. Informant's Name/Relationship (7 Frank J. Mai		19b. Mailing Address (Street and Number or Ri 1 1803 Nuthatch Ct,		
Important: if item eny injury or othe once.	20a. Method of Disposition 1 Disposition 2 Cremation 3 C	THEITIOVALITORI STATE	Place of Disposition (Name of cemetery, crematory or other place)		Location - City or Town, State
Important eny injury once.	4 ☐Donation 5 ☐ Other (Specify 21. Signature of Functal Service Licen		oudon Park Cem. 4/13		Saltimore MD
odei e succian	shock, or heart failure. List only	plications that caused the deat	Charles L. Stev 1501 E. Fort Av	enue, Bal	timore MD 2123 Approximate Interval Between Onset and Death Vew 1
edical miner	disease or condition resulting in death)	Due to (or as a conseq	(uence of):	ovis tast	Vears
the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o			yews
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s been signed by should be detailed by be detailed by Philipping	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying cause given in Part I.		use contribute to the cause of death?
page 2 should be c	Hyperten.	sion		24a. Was an autopsy performed?	24b. Were autopsy findings availar prior to completion of cause death?
actor, p	25. Was case referred to medical examiner?	Hospital:		ath (Check only one)	
where this of uneral dir	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work?	dome 5 Residence 28d. Describe how inj	
ed in by the funeral	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	9 290 Place of Injury At h	M 1 ☐ Yes 2 ☐ No ome, farm, street, factory, office fy)	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
within 24 hours affer beauti. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2: Medical Certification: To Be Compl			owledge, death occurred at the time, date and placation and/or investigation, in my opinion, death occ		
To th compl	29b. Signature and title of certifier	my!	P 29c. License number D 5 f 3 9	1 Ap	Pate signed (Month, Day, Year) VI L 12, 200
0	30. Name and address of person who	completed rause of death (Item	Tuence, Baltimo	re Mari	1and 2122
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	7	

The law requires that the death certificate be executed Box 68760, P.O. Records, of Vital Hospital or Attending Physician: Division

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Director

Funerai

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Completed

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and Mental Hygiene. and Mental Hygiene. Is marked other then "natural", or itema 23a or 28a-f show varimatic event, the Medical Examinar must be exitting at

permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 ie eny injury or other trau once.

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-translt Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC certificate has been s rector, page 2 should DISEASE : After this certifical funeral director, I 25. Was case referred to medical examiner? Be 1 Yes 2 No Medicai Certification: To 27. Manner of Death 5 Pending investigation s after dec. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 Feyssa 00 APRIL 06 2006

State Registrar EYOB

31. Date filed (Month, Day, Year)

FEYSSA

30. Name an ad ress of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

ST

BALTIMORE

MD 21225

lister, William 1	- For State	state of Maryl	se Type or Pri and / Departm Certific	nent of	Health a	and M	lental Hy		Reg. No.	200	16	1154
Physician/	Registrar 1. Decedent's Name (First, Mide	ldle,Last)					2	Date of De Month	ath Day	Year		Fime of Death 8:45
cal Examiner		Michael	McCalliste					April 11,		County of E		0.43
	4a. Facility Name (if not institut 2927 Glendale Aven		number)	4	b. City, Town Baltimore	е				١	N/A	one (State or Ears
Funeral Director	5. Social Security Number 218-44-6631	6. Sex	7. Age (In yrs. last bi		If Under 1 Months		Under 24Hrs. Hours Min.			1947	Countr	ace (State or Fore y) yland
	Usual Residence of Decedent 10a State 10b. Count		10c. City, Tow									d. Inside City Lim
how a	Maryland N/	/A	Ва	ltimo	re				000			
he Maryland t or 28a-f shu ified at once Director	10e. Street and Number 2927 Glenda	la Avenue			10f. Zip Cod	de	21234			izen of What nited		
th the 23a or notifie			ecedent Ever in U.S.	13. Wa	s Decedent o	of Hispan	ic Origin? (Sp	ecify Yes or	No-			Indian, Black,
or items 23 nust be no Funeral	11. Marital Status 1 Never Married 2 X	Married Armed	Forces?	If Y	es, specify Co	uban, Me	exican, Puerto	Rican, etc.)		White,		White
after of all. of all.		Divorced If Yes, Give or Dates:	Y I C CII aiii	n Docador			Give kind of w	ork done	16b	Kind of Busi	iness/Indi	ustry
5-0036 set within 72 hours after gygiene. other ithan "matural" the Medical Examine Completed by	15. Decedent's Education (S Elementary/Secondary (0-1 12 yrs.		grade completed) 10: dur e (1-4 or 5+)	ing most of	working life. [DO NOT	use retired)			Balti	more	City
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica Be Comple		dlo Last)		Г	OTTCG	18.1	Mother's Name	(First, Middl				3
Hygh Hygh	17. Father's Name (First, Midd		lister				Ethel	Mary	, Mor	ntgome	ry	
21215 ould be filt d Mental H s marked ite event, f	Granville 19a. Informant's Name/Relation		113 001	19b. Mailin	g Address ((Street a	nd Number or I	Rural Route	Number, I	City or Town	n, State, Z	tip Code) and 2121
Ore, I	20a. Method of Disposition 1 X Burial 2 Crema	ation 3 Remov		matory or o	sition (Name	Of Cerrici	.c.ry,	Date				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit. Pages I and 2 should be filed within 72 hours after 33a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4 Donation 5 Othe 21. Signature of Europat Sen	er Specify: vice Licensee Mi C	Dular hael E. Canap	ney Val	ley Mem	ddress of	Ruck	Inc.	Ba	altimo	re,	MD 21214 Approximate Interest Between Onset
Baltin Baltin By Bhysician Charles Cha	4 Donation 5 Othe 21. Signature of Funeral Sen	er Specify: vice Licensee Mi C e, or complications thause on each line. ease a Atherps	Dular hael E. Canap	ney Val	Name and Action Leonar the mode of contract the mod	ddress of	Ruck	Inc.	Ba	altimo	re,	MD 21214 Approximate Inte
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(Creex only one) 2 Medical Exam 29b Signature and title of certifier

12117

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimpre, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

State 31. Date filed (Month, Day, Year). 32. Registrar's Signature apistrar APR 1 3 2006 ORIGINAL

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

April 11, 2006

DHMH 17 Rev 1/2001 OCME 10/2003

Registrar

		1	For State Registrar	State of Ma		•		of He	ealth a		ental Hyg	iene	06	1155	50
Ė			Decedent's Name (First, Middle, Last)								2. Date of Dea		Year	3. Time of	Death
	Physicia /Medic		George R. Macle	an							April	11, pay	2006	8:30	Ам
	Examin		4a. Facility Name (If not institution, give stre						Location of				ounty of Death		
			Renaissance Gar						ville				Baltim		
	Funeral		5. Social Security Number 6. Sex 15 N	7. Ag	e (In yrs. la S	st birthday) 6 Yrs.	If Under Months	Days Days	If Under Hours	Min.	8. Date of Birth (Month_Day Nov 5,	Year) 1010	9. Birth	place (State o intry) York	r Foreign
	Director	-	Usual Residence of Decedent			00 113				1.	NOV 3,	1919	Ivew	TOLK	
	land	-	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside Cit	ty Limits
	Mary 1 sh	ţ	Maryland Baltimor	е		Caton	svill	e						1 🗆 Yes	2 XN0
	r 28e	irec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	intry?	
	23a o	Funeral Directo	715 Maiden Choice	Lane CR	312			21	.228			U	SA		
	deat	ner	11. Marital Status 12.	Was Decedent Armed Forces?	40/	. 13. V	Was Deced	ent of His	spanic Ori	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14	. Race - Amer Black, White		
õ	or its	근	1 Never Married Married	1∑Yes 2 ☐ I	№ 194 194	13	1 ☐ Yes 2		Specify:				pecify: Wh	_	
9500-61212	urai',	d by	3 Widowed 4 Divorced	Year or Dates:		16a. Deced	lont's Heur	I Occupa	ition	-	1		of Business/I		
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7	with iene. ther	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Col	lege	Prof	esso	r		Ed	ucatio	n	
0	filed Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle,	Maiden Si	urname)		
yland	iges 1 and 2 should be filed within 72 hours after death with the Maryland 11 of Healih and Mertal Hygiene. If if them 27 is marked other than "natural; or items 23a or 28e-f show or other treumatic event, the Medical Examination at the incitited at	ToB	George Maclean							-	Runde:				
Mar	and l		19a. Informant's Name/Relationship (Type								Route Numbe				01 000
≥ .	and ealth m 27	-	Diana A. Maclean,	Wite	an Di						CR 312		INSVILL		21220
0	pes 1 t of H if ite or otl		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Ren	noval from State		nce of Dispo									d
	tmen tent:		*4 □ Donation 5 □ Other (Specify)	-	Meti	o Cre							imore,		
Baitimore,	permit. Pages to Depertment of Histoportent: If its any injury or ot once.		21. Signature of Funeral Service Uiceos Thomas Gregor	y		2	remat 99 Fr	ion	Soci	ety (koad	of Mary Baltim	land ore,	Inc. Maryla	nd 2122	28
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused cause on each li	d the death. ne.	Do not ent	er the mod	e of dying	g, s <i>u</i> ch as	cardiac o	r respiratory ar	rest,		Approximat Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition		(1	111	Du	igo	pi	lly				Criser and I	D Guill
	/Medical Examiner		resulting in death)	Due to (or as	a consequ										
	·	-	Sequentially list conditions, b.	Due to (or as	a consequ	ence of):									
Ţ	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
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/60	eath certificate be executed attending physicien end for use as the burial-transit	cail	d.												
9	tifical g ph as th		IE SELVALE						<u> </u>						
ROX	death certifica e attending ph ed for use as th	lan/Med	23b. Was decedent pregnant	: If yes, outcome 1☐Live birth			Ectopic pr	egnancy				23	d. Date of deli Month		Year
O.	0 0	Physici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of de	ath 5□	Other (sp	ecify)				10			
J.	that the de led by the a detached f		Part II. Other significant conditions gontr	ibuting to death&	out not resu	Itina in the u	nderlvina c	ause dive	en in Part	J.	23e. Did to	bacco use	e contribute to	the cause of o	death?
g,	og Dec	d by	De	mente	1		,				101	′es 2.⊟	No 3 □ Pr	obably 4 🗆	Unknown
Š	v require been si should b	etec									24a. Was	an	24b. Were au	tansv findings	available
Records,	The law ate has page 2 t	Completed									autop perfo	rmed?	prior to death?	ompletion of c	ause of
Vital	(0	e Co	25. Was case referred to medical						26 Plan	e of Death	1 ☐ Yes (Check only o		1 🗌 Yes	2 140	
	Physicien: r this certific ral director,	0	ovaminor?	spital:	ent 2 🗆 8	ER/Outpatier	nt 3 DC	Othe	25	/	ne 5 Resid		Other (Spec	cify)	
ō	g Phy er thi	2	27. Manner of Death	28a. Date of Inju (Month, Da	ury v Year)	28b. Time o	f 2	8c. Injury	at k?		28d. Describe h	now injury	occurred		
ö	Attending For death. ector: After by the funera	atio	1 Natural 5 Pending 2 Accident investigation	(,,	М		Yes 2						
Division	after de Directe d in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At hor tc. (Specify	me, farm, sti)	reet, factory	, office			28f. Location (S City or Tow		Number or Ru	ral Route Nurr	nber,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier Certifying Physic (Check only one)	cian: To the best er: On the basis of and manner st	of examinati	vledge, deat ion and/or in	h occurred vestigation	at the tim , in my of	ne, date a pinion, de	nd place, a ath occurr	and due to the ed at the time,	cause(s) a date and p	ind manner as blace, and due	stated. to the cause(s	5)
)	To the within To the	Me	29b. Signature and title of certifier	Zar	4	14	290	c. License	o number	2009	40	29d. Date	signed (Monti	n, Day, Year)	
	(X)		30. Name and address of person who com	pleted cause of	death (Item	23а) (Туре,	Print)	, , ,	Ones		lucce (- 1	11/16	[0	
	0			32. Renisf	rar's Signat	ure	10	10	LUNC	1	(301	126	1 Cold	1 4	D
	Sta Registi		31. Date filed (Month, Day Year) 3 20	08	ONE of	12 A	Search .	Ď			CIL	Le		7/	776
		2 .		and the same		7									

LATOYA MASSEY 06-02105 RJ

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Inpend item#23a, 27, perME, 2854, 4/27/06 TT

J	•	Unpend item#23a, 1 - State Registrar	State of Ma		artmen e <i>rtificat</i>			and M		giene Reg. No.	006	11551
		1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ith Day	Year	3. Time of Death
Physicia /Medic		LATOYA ANN MASSEY							March 2	6, 2	006	5:47a. [™]
Examin		4a. Facility Name (If not institution, give				Town, or					County of Deat	
		Fort Washington Med				rt Wa	IShir If Under				ince Ge	eorge's hplace (State or Foreign
Funeral Director		5. Social Security Number 6. Security Number 1	M 2₹ F	(In yrs. last birthda) 16 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da 9-22-19	y, Year)	Co	HINGTON, DC
		Usual Residence of Decedent			1				7 22 1.	,0,	WZID	minoron, be
Mow #		10a. State 10b. County		10c. City, Town or l								10d. Inside City Limits
- Pag	cto	MD PRINCE G	EORGES	FORT WA	SHING	ron						XX Yes 2 No
or 28	Director	10e. Street and Number			10f. Zip						ten of What Co	ountry?
8 23e	rai	805 BRAEBURN STRE		rania II C 12	Wes Dass	207		aia2 /Ca	asitu Vas as Na	USA	4. Race - Ame	nicas Indias
Item Tare	Funeral	11. Marital Status 1X Never Married 2 Married	12. Was Decedent Endemoder Forces? 1 ☐ Yes 2 No.		If Yes, spe	cify Cubar	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	
ar, or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	⊉ □ No	Specify:				Specify: BL.	ACK
leal E	ted	15. Decedent's Edu (Specify only highest grad		16a. Dec	edent's Usu	al Occupa	tion	t of work	no.	16b. Kir	nd of Business	Industry
Mad "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) life.	DO NOT u	se retired)	aning mos	(O) #O/A	,,,9			
ygien rt, the	Co	0		STUI	DENT		10 14-15-	de News	(First Ministr	Maidae	Cumama)	
d oth	Be	17. Father's Name (First, Middle, Last) PHILLIP DIXON							(First, Middle. MASSEY	маюеп	Sumame)	
narke narke	T ₀	19a, Informant's Name/Relationship (Ty	ine Print)	19h Mai	ling Address	(Street a			al Route Numbe	r City or	Town State	Zin Code)
th an		BEVERLY MASSEY/MOT			-				SHINGTO			
Heal tem 2 other		20a. Method of Disposition		20b. Place of Disg	osition (Na	me of			Date	20c. Lo	cation - City or	Town, State
Department of Health and Mental Hygiene. Important: If Item 27 I e marked other than "nature!", or Items 23a or 28a-f show sny injury or other traumatic event, the Medical Execution must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	WASHING				-6-2	2006	SUIT	CLAND,	MD
oortal		21. Signature of Funeral Service Licens	ee ^	00	22. Name a	nd Addres				FUN	IERAL H	OME OF MD
Department on it		Hulla P.M	austra	ll 1	4308 S	UITL	AMND	RD.,	SUITLA	AND,	MD 207	46
the Funeral Director: After this certificate has been signed by the attending physicien and positive funeral Director. After this certificate has been signed by the attending physicien and positive funeral director, page 2 should be detached for use as the burial-transit of positive funeral director.	dical Examiner	flary, lading to inmediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of): consequence of):	bral pa	1sy						
ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal death 3	□Ectopic p					2	3d. Date of de Month	livery Day Year
signed by the a d be detached f	þ	Part II. Other significant conditions con	ntributing to death but	t not resulting in the	underlying	cause give	n in Part I		23e. Did t			o the cause of death?
been si should I	Completed								24a. Was	an	24b. Were at	utopsy findings available
has ye 2	E D								autor perfo	sy rmed?	prior to death?	completion of cause of
certificete rector, pag	e Co	25. Was case referred to medical					26 Place	of Doot	1) Yes	2 No	1 Yes	2 □ No
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er thi		27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time	of	28c. Injury Work	at		28d. Describe I			
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within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, s (Specify)	street, factor	y, office			28f. Location (City or Tou	Street and vn, State	d Number or Ri	ural Route Number,
n 24 hour ne Funera sletely fille	edical		sician: To the best of ner: On the basis of and manner stat	examination and/or								
To t	ž	29b. Signature and title of certifier	Don.		29	c. License	number			29d. Dat	e signed (Mont	th, Day, Year)
		Hotele	tolle	~ 00		OCME				Marc	h 27, 2	2006
		30. Name and address of person who co		1 / /		1 -	~		T			1 04004
		TATRICIA ATT	SO CON- TE	-	11 در	1 Per	ın St	reet	Balti	more	, Maryl	and 21201
Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	C. H.	,						

			For State Registrar	State of Mar	yland /		rtment of <i>ificate o</i> a		Mental Hy	giene Reg. No.	006	11552
			1. Decedent's Name (First, Middle, Last)					2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		Ramona	D.		Mali			APZ, C	10	2006	6.05 A M
	Examin	er	4a. Facility Name (If not institution, give BACRIMORE, WASHING	TON MEDIC	AL G	ENTBE	2 614	or Location of Dea	NA	AN		FRUNIXEL
	Funeral Director		5. Social Security Number 6. Security Number 101-26-6776	TM OFF	In yrs. last 71	birthday) Yrs.	Months Day		8. Date of Bi (Month, Date) May 1	rth ay, Year) 7,1934	9. Birtt Co. Pen	nplace (State or Foreign untry) nsylvania
	pu .		Usual Residence of Decedent 10a. State 10b. County	1	I0c. City, T	own or Loc	ation					10d. Inside City Limits
	Aaryla f eho	5	Maryland Anne Ar		Pasa							1 ☐ Yes 2 ☐ No
	the N	rect	10e. Street and Number	under	1 dbd	della	10f. Zip Code)		10g. Citiz	en of What Co	untry?
	3a or	Funeral Director	8485 Kenton Road				211	22			U.S.A.	
	deetl	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. W	as Decedent of Yes, specify Ci	f Hispanic Origin? (Jban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0- 1	4. Race - Ame Black, White	
36	be filed within 72 hours after deeth with the Maryland Hygiene. Hygiene Hygiene do other then "natural; or iteme 23a or 28a-f ehow do other then "natural; or iteme 23a or 28a-f ehow event, the Madical Examinar most be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			□Yes 2 🖳 🔨		,			hite
Maryland 21215-0036	2 hou		15. Decedent's Ed (Specify only highest grad	ucation	1	6a. Deced	ent's Usual Occ	upation ne during most of w	orkina	16b. Kin	d of Business/	Industry
7	be filed within 72 Ital Hygiene. Id other then "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. D	O NOT use reti	red)			1, T	
2	filed w Hygien other th	Co	12 17. Father's Name (First, Middle, Last)	N/A		Cont	rol Des	k Operato	or ame (First, Middle		wling L	ane
and	ould be fi Mental H erked ot atic ever	Be c	Leo			Pollo	ck	Hele		o, maroor c	1,000	Mizak
2	ss 1 and 2 should bot Health and Ment item 27 is marked rother treumatic	٦	19a. Informant's Name/Relationship (7	ype, Print)	_			et and Number or F	Rural Route Numi	ber, City or	Town, State, Z	Zip Code)
	and 2 : ealth ar n 27 ie		Harry J. Malick (Husband)		8485	Kenton	Road Pasa	adena, Ma	aryla	nd 2112	2
ē,	of Health item 27		20a. Method of Disposition		20b. Place ceme	e of Dispos etery, crem	ition (Name of atory or other p	lace)	Date	20c. Loc	ation - City or	Town, State
Ë	Pages nent of ant: if it ary or o		1 ☑ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Glen	Have	n Memor	ial Pk. 4	4/15/06	Gle	n Burni	e, Maryland
Baltimore,	permit. Pages Department of I Important: if it eny injury or o		21. Signature of Fune al Service Licen:	Ellina		²² M	Name and Add CCully- 204 Mou	ress of Facility Polyniak Intain Roa	Funeral ad Pasad	Home ena. l	, P.A. Marylan	d 21122
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused the	ne death. [Approximate Interval Between
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	/Medical Examiner		f	Due to (or as a	consequen	ice of):						
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8760,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequen	ice of):						
287	icate physics the	edical		d								
Box (nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Catania aurana			2	3d. Date of del	ivery
	The law requires that the death certificate has been signed by the attending I age 2 should be deteched for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 4□Pregnant at tir 9□ Unknown			Ectopic pregna Other (specify)				Month	Day Year
P.O	het th	Phy	Part II. Other significant conditions co	ontributing to death but	not resultin	na in the un	deriving cause	given in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
Records,	uires the signed Id be de	d by	, are in			•	,	3	1 🗆	Yes 2]No 3∏Pr	obably 4 Yunknown
S	w require been signature	lete							24a. Wa	s an	24b. Were au	atopsy findings available
æ	The law te has	Completed							auto per 1 Yes	opsy formed? 2 No	death?	utopsy findings available completion of cause of
<u>ta</u>		BeC	25. Was case referred to medical examiner?					26. Place of D	eath (Check only			
<u>></u>	hysic this ce al direc	To	1 Yes 2 No	Hospital: 1 patient	2 □ ER	/Outpatien	3 DUA		Home 5 ☐ Res			cify)
Division of Vital	Attending Physician: The in death. ector: After this certificate hiby the funeral director, page	inol :	27. Manner of Death 1 ■ Matural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28	b. Time of Injury		njury at Vork? ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred	
Sic	or Attend efter death Director:	licat	2 Accident investigation 3 Suicide 6 Could not be		v - At home	e, farm, stre			28f. Location	(Street and	d Number or Ru	ural Route Number,
<u>≥</u>	를 를 들	Certification:	4 Homicide determined	building, etc.	(Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	own, State)		
	To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	edical C		yaician: To the best of niner: On the basis of e and manner state	examination							
	thin 2 the othe	Med	29b. Signature and the of certifier	and manner state			29c. Lice	ense number		29d. Date	signed (Mont	h, Day, Year)
	F 3 F 8) Salarla	10	mi	>	D'	45,40	î	Ape	16	2006
,	10		30 Name and advess of person who	completed cause of dea	ath (Item 2)	3a) (Type	Print)	Cal 20 M	Bura	IUP	mo .	2061
	Sta	ato.	31. Date filed (Month, Day, Year)	32. Pigistrar	's Signatur	0		1				
	Regist			2006 Kenn	e l	K A	asser .	<u> </u>	*			

Amend item#18 perFH C854.4/18/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
 NORMA JANET 2. Date of Death 3. Time of Death METZGER **Physician** Month Year 6:15 P April 05 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lansdowne Baltimore County 19 Laverne Ave. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) June 05 1931 9. Birthplace (State or Foreign **Funeral** 1□ M 2√□ F 74 215-28-5095 Yrs Maryland Director Usual Residence of Decedent 10a. State Md Baltimore Co. City, Town or Location Lansdowne 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examinar trust by notified at 1 ☐ Yes X ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21227 19 Laverne Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: þ Specify: ¾□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Maryland Box Company Packer 18. Mother's Name (First, Middle, Maiden Surname)
Anna F. Manning 17. Father's Name (First, Middle, Last) and Mental h Pages 1 and 2 should be Clarence Sloat Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Laverne Ave., Lansdowne, Md. 21227 If Item 27 I (Daughter) Susan Davidson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Glen Haven Mem. Pk. 4/10/06 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signitive of Funda Service Licensee 22. Name and Address of Facility Polyniak Funeral Home P.A 237 E. Patapsco Ave. Baltimore, Md.21225 J. Wayne Usterling 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** LUTESTINAL /Medical Due to (or as a consequence of): Examiner PERITONEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Astric signed by the attending physician and does detached for use as the burial-trans Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 1NO 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No s certificate has t lirector, page 2 s 24a. Was an 1 Yes 2 4No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ØNo 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Z Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/06. 828387 Mo 30. Name and address of jerson who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTIL - EMLINONE INO. SARDI JEL KINDO 31. Date filed (Month, Day, Year) -- --32. Pagistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend Item #26 Per Phy G854 4713/68 teget Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4-5-2006 4:00 PM Eula Murial Martin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 937 12th Street Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 238-28-1480 Director 85 4-3-1921 NC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Mudical Examiner must be notified at 1 Yes 2000 Directo Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a 1049 7th Street 21060 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 XWidowed 4 □ Divorced Year or Dates: "naturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Meat Department Grocery permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Tucker Carrie Leviner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 937 12th Street; Pasadena, MD 21122 Mr. Lonnie Duane Martin son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 4-10-2006 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home, PA Mo/3571 Second Ave SW; Glen Burnie, MD 21061 lash ll. Vancura 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition heart Valvular **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed burial-transit and Due to for as a consequence of Records, P.O. Box 68760 the ettending physicien hed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 Yes 2 Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home Thesidence NOther (Specify) Residence 1 ☐ Yes 2 No ္ပ 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director: d in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

State Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

APR 1 3 2006

32. Registrar's Signature

D44804

who completed cause of death (Item 23a) (Type. Print) VOIX MD 8 28 Ritch 1ê Huy Fuite 134 Maradena MD 2112

Amend item#30, perIWR, G854,4413/06 IT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician MARCH 28, 2006 NORMAN F. MILLER 6:35 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL P.G. CHEVERLY, MARYLAND If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F 50 Director 577-76-7629 Yrs 7/15/55 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28a-f show Exeminer must be notified at 1X Yes 2 □ No Completed by Funeral Director DC Washington, D.C. 10f. Zip Code 10g. Citizen of What Country? 3504 Minnesota Avenue, S.E., #2 20019 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. If Item 271s marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Caterer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johnnie Miller Shirley Wheeler ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Seaton Place, N.E, Washington, DC 20002 Edmund Jefferson Miller f Health in Item 27 I 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \$ = 6 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. April 6,2006 Hyattsville, MD Harmony Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Frazier's Funeral Home, Inc. DESHAUN WATTS 389 Rhode Island Avenue, N.W., Wash., DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ENPSTAGE DISERS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) **burial-transit** or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the for use as IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 40 of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one 1 ☐ Yes 2 🛂 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation ours after death. neral Director: Afi filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled i o the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 818 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ceril Donald George, MD Prince George's County Hospital CHeverly, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 3 State 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2:208 M 2006 Marian /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Anne Arundel Glen Burnie 1423 Tieman Drive If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 28, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 🛛 F 216-22-4089 89 Director Harrisburg, PA Usual Residence of Decedent 10a. State MD Anne Arundel 10d. Inside City Limits 10c. City, Town or Location or 28a-f show Glen Burnie other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1423 Tieman Drive 21061 USA or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. I mortrant: If tiem 27 is marked other than "natural", or then any injury or other traumatic event. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Pennsylvania Clerical 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mamie A. Grim John N. Shepler ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1423 Tieman Drive Glen Burnie, MD 21061 Sandra Moore/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 3, 1 ☐ Burial 2 Stremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD Bayview Crematory 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final 18 chemic Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 9 war 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 MNo
9 ☐ Unknown Month Day Year 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 🗆 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 Yes 1 Tyes 20 25. Was case referred to medical examiner?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After 5 Pendina death. investigation M 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: completely filled in by the in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accounted at the counter of the cause (s). 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00389 30. Name and address of person who completed cause of death (It in 23a) (Type, Print) Vakw 800 31. Date filed (Month, Day, Year)
APR 1 3 2006 32. Registrar's Signature State Registrar

VOID
CERTIFICATE **

11557

SEE

CERTIFICATE #

02792

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year April 2, Alice Marie Pritchard 2006 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death renter Frederick

7. Age (In yrs. last birthday)
Months Days Hours Min. (Month, Day, July 1, Crumland Farms Health Center Frederick 5. Social Security Number 6. Sex Funeral Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Director 219-12-7806 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exam art must be notified at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2X No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7150 Bowers Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Supervisor Telephone Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ٥ William Howard Wheeler Mary Virginia Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Pritchard/son 7150 Bowers Road Frederick, MD 21702 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 ⊠Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director (delle 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): mmo /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 Probably 4 □Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? acompte 21 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 ursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division of Vital Records,

Box 68760,

P.O.

D.O.D.

State Registrar

Auskn 31. Date filed (Month, Day, Year) 3 2006

29b. Signature and title of certifier

(Check only one)

to 32. Registrar's Signature

icrne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0968

29d. Date signed (Month, Day, Year)

		•	For State Registrer	State of Marylan	•	artment rtificate				giene	6	1559
	A S		1. Decedent's Name (First, Middle, Last	1)					2. Date of Dea Month	Day	Year	3. Time of Death
	Physici /Medio	. 80	BARBARA ANN PARA						APRIL	05,	2006	7:45P M
	Examir	er	4a. Facility Name (If not institution, give					cation of Dea		4c. Count		DV
	Funcial		WASHINGTON ADVEN' 5. Social Security Number 6. Se		last birthday)	If Under 1	Year If	A PARI	S. 8 Date of Birt	h	9. Birthp	ACS (State or Foreign try)
	Funeral Director			тм ЖЖ́г	51 Yrs.	Months [Days H	Hours Mir	NOV. 21	, Year) , 1944	NORT	H CAROLINA
	Du >		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Lo	eation					1	Od. Inside City Limits
	ours after death with the Marylan ral', or Iteme 23e or 28e-f ehow Exeminer must be notified at	ō			•							1XXYes 2 □ No
	28a-	Funeral Director	MD PRINCE G	EURGES III	ZATTSVI	10f. Zip C	ode			10g. Citizen of	What Coun	try?
	h with	ie ie	1836 METZEROTT R	OAD #706			20	783		UNITE	D STA	TES
	deat	nera	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Deceder	nt of Hispa	anic Origin? (Specify Yes or No- into Rican, etc.)	14. Ra	ce - Americ	
36	or It		1 Never Married 2 Married 3 Widowed XX Divorced	1 ☐ Yes XX No		1 ☐ Yes X		Specify:	, , , , , , , , , , , , , , , , , , , ,		ή: BLA	
5-0036	72 hours after death with the Maryland natural; or Iteme 23e or 28e-f ehow digal Examinational be notified at	ed by	15. Decedent's Ed	Year or Dates:	16a Dece	dent's Usual (Occupation	n		16b. Kind of 8		
15	n "na	Completed	(Specify only highest grad		(Give	kind of work DO NOT use	done duri	ng most of w	orking	TOO. Tally of E	303/1033/110	
2121	d within giene.	E O	Elementary/Secondary (0-12)	2 YRS.	PROCU	REMENT	SPE	CIALIS	ST	GOVE	RNMEN	T
밀	be filed within 72 ho ital Hygiene. id other then "natur event, the Modical	Be	17. Father's Name (First, Middle, Last)				18	. Mother's N	ame (First, Middle,	Maiden Suma	me)	
yla		ဥ	JOHNNIE MACK						MAE GLA			
Maryland	d 2 sho		19a. Informant's Name/Relationship (7						Rural Route Numbe			,
	Heal Heal ther		MALINDA COLEMEN 20a. Method of Disposition	20b. F	Place of Dispo	SUMMER sition (Name	of	KD.	TEMPLE H	20c. Location		
Baltimore,	0 0		XX Burial 2 Cremation 3 : 4 Donation 5 Other (Specify	Hemoval from State	cemetery, crei	-		M OAA	14/2006	מווד דון	AND,	MT
alti	그 문문을 .		21. Signature of Funeral Service Licens						AL HOME			
Ö	Depa Impo eny I		1.7.91	noll		4308 S	SUITL	AND RO	AL HOME AD SUITL	AND, MD	2074	6
			23a. Part1 Enter the disease, or comp shock or heart failure. List only of	lications that caused the deat one cause on each line.	th. Do not ent	er the mode	of dying, s	such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ANOXIC		cefi	HAL	OFA	THY			10 DAYS
- A	Examiner			Due to (or as a conseq	tuence of):	/	100	-	CA. Tur			2-1-11
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	luence of):		Elin					1116/0119
/	cuted nd ransit	Examiner	that initiated events	SEVERE C	25000	ARU	A	21512	y D.	SEASE	_	YEARS
,00	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or as a conseq	quence of):							
8760,	ate he	dicai	•	d								
9 xo	death certifica attending phate is a for use as for	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancv					234 D	ate of delive	D/
Bo	atten after u	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes ※※No	1 Live birth 2 Feta	al death 3[Ectopic preg						Day Year
0	that the d ed by the detached	hysi	9 Unknown	9□ Unknown								
S, D	es thai igned t	by P	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cau	ise given i	n Part I.	23e. Did to	bacco use cor	ntribute to th	e cause of death?
Records,	w require been sig should b	ted	CHRONIE K	ENAL 1-13	dur	£ .			1 🗆 ١	'es 2□No	3 Prob	ably XX Unknown
ecc	e lawr has be je 2 sh	Completed	Fulmounky	EDEINA	7				24a. Was autop	SV	prior to cor	osy findings available npletion of cause of
E	The l	Con	RESPIRATOR	y 1N500	11/0	LIEN.	04		1 Tes	med? XXNo	death? 1 ☐ Yes	2 🗆 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other		eath (Check only o			
of	Phys r this ral dii	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o		c. Injury at Work?		Home 5 Resid			"
lon	nding f th. :: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М		2 🗆 No				
Division	I or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, sti	reet, factory,	office		28f. Location (S City or Tow	Street and Num	iber or Rura	l Route Number,
Ö	ital or A irs after ral Direct led in by	Cer										y sultiminately account
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		ysician: To the best of my kno iner: On the basis of examina and manner stated.								
	o the	Me	29b. Signature and tile of certifier	And marrier states.		29c. I	License n	umber		29d. Date sign	ed (Month,	Day, Year)
	FSFO		Adly a	1411		2	16.	5-5-1		4-1	1 - 1	/-
-	5		30. The an a dress of person who d	completed cause of death (Ter	N 23%) (Type)	Print)	15 -	-		6	0	20913
			JAMIR NEIM	et ami	7615		Cell	1948	TAKE	na th	RK,	mo.
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 3 200	32. Registrar's Sido	ature	Si de					,	

			For	State of Maryland	/ Department of Health an	d Mental Hygie	enns	11560
			1 State Registrar 1. Decedent's Name (First, Middle, La	st)	Certificate of Death	Reg. 1	No.	3. Time of Death
	Physici /Medic		Louise		SOM	ADVI S	Day Year	8 23 AM
	Examin		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of D	eath	4c. County of Death	7,4
	Funeral		5. Social Security Number 6. S	est far h We	birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth	N /	hplace (State or Foreign
*	Director		213-28-8134	OM 200 85	Yrs. Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, Yea July 22	1920 SOV	the Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location			10d. Inside City Limits
	a-fsh	ctor	MD n	14	Baltimore			1 Pyes 2 □ No
	death with the Maryland ima 23a or 28a-f show Irmus Les notified at	Funeral Director	10e. Street and Number	1-1 1 2	10f. Zip Code	10g.	Citizen of What Cou	untry?
	ma 234	eral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P	(Specify Yes or No-	14. Race - Amer	ncan Indian,
98	or its	y Fur	1 Never Married 2 Married	1 Yes 2 No	If Yes, specify Cuban, Mexican, Polymer 1 ☐ Yes 2 ☐ No Specify:	uerto Rican, etc.)	Black, White	i, etc.
9	72 hours after natural', or ite	ed by	3 Dividowed 4 □ Divorced 15. Decedent's Ed	Year or Dates:	6a. Decedent's Usual Occupation	16h	. Kind of Business/li	1CK
21215-0036	within 72 ene. than "na	Completed	(Specify only highest gra Elementary/Secondary (0-12)		(Give kind of work done during most of life. DO NOT use retired)	working) M	No.
	filed with Hygiene. other than	Con	17. Father's Name (First, Middle, Last)	NIA	Coin / Chine C	DAVITOV L. Name (First, Middle, Maid	OIN // BIL	Chine Co.
lan	ould be Mental Marked o	To Be	Covan Mc	Knight	1.11	it on	10 V.S	
Maryland	2 sh and Is m		19a. Informant's Name/Relationship (Type, Prin	19b. Mailing Address (Street and Number of	Rural Route Namber Cit	y or Town, State, Zi	ip Code)
_	1 and Health Iem 27		20a. Method of Disposition	SON COLUMN 20b. Place	of Disposition (Name of	Date 20c.	Location - City or T	D 21215
Baltimore ,	Pages nent of int: if it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Hemoval from State	etery, crematory or other place)	12-00 Pm	wholleton	1111
3alti	permit. Pag Department Important: eny injury c		21. Signature Fundal Service Light		22. Name and Address of Facility	11 270 F	redhi Hor	Pass
-72	40 = 0		23a Part 1 Enter the disease or com	nlications that caused the death.	Oo not enter the mode of dying, such as car	14 Batto	my.	21239 Approximate
1 24 30 8	Physician		shock, or heart failure. List only fmmediate Cause (Final	one cause on each line.	t (nno	diac of respiratory arrest,		Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequent	ce of):	10.10		
18K	Examiner	<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Unconto	200	tention	2	
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c	00			
90,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a consequent	ce of):			
68760,		edicai	•	d				
Box	th certite tending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	
P.O. E	 requires that the death certific been signed by the attending p should be detached for use as 	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown			Month	Day Year
σ.	s that t	by Ph	Part II. Other significant conditions o	ontributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	equire sen sig lould b	ted t				1 🗆 Yes	2 □No 3 □ Pro	bably 4 Unknown
Zec	has by	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
	an: Th tificate tor, pag	Be Co	25. Was case referred to medicaf		26 Place of	1 ☐ Yes 25(1) Death (Check only one)	No 1 ☐ Yes	200
Division of Vital	hysici his cer il direc	ဥ	examiner?		Other	g Home 5 Aesidence	6 □Other (Speci	ify)
ono	ding P h. After I funera	tlon:	27. Manner of Death 1 Natural 5 ☐ Pending 2 Accident investigation	(Month, Day Year)	b. Time of Injury at Work? M 1 Yes 2 No	28d. Describe how in	jury occurred	
VISI	Attendi ar death. ector: A by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined			28f. Location (Street City or Town, Sta	and Number or Rur	ral Route Number,
	Hospital or 24 hours afte Funeral Dir itely filled in							
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my knowled niner. On the basis of examination and manner stated.	dge, death occurred at the time, date and pl and/or investigation, in my opinion, death o	ace, and due to the cause courred at the time, date a	(s) and manner as a and place, and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	PULLED	29c. License number	29d. C	Date signed (Month,	, Day, Year)
3			- Uniceal	7	1940305	> -	1/12/20	706
	γ		30. Name and address of person who ANURADHA	REDDY (1)	a) (Type, Print) 62 1 6	Baltin	steet MI	2120/
Ä	Sta	_	31. Date filed (Month, Day, Year) APR 1 3 2	32 degistrar's Signature	Roselle .			,
* 4	Registr	-11	WLUTOS	006 Degue St				

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State

Registrar

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Meria

2006

Fernando

31. Date filed (Month, Day, Year)

22 S. Greene

32. Registrar's Signature

			1 - For State Registrar	State of Marylan		artment rtificate			nd Mental	Hygien	2006	11562
	Dhuaiai		1. Decedent's Name (First, Middle, Last)							of Death	ay Year	3. Time of Death
	Physici /Medio		Dorothy Elizabet						A.	ul ll	2000	850 D W
	Examin	er	4a. Facility Name (If not institution, give s Baltimore Washingt	,	nter	4b. City, T	own, or	Location of I	Death	4	c. County of Death	/
	Funeral		5. Social Security Number 6. Sec			If Under 1		If Under 24	Hrs. 8. Date	of Birth th, Day, Yea	9. Birth	place (State or Foreign
	Director		217-03-7900	M 202F 85	Yrs.	Months	Days	Hours	Min. Sep	14,	1920 Mar	yland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	Mary a-f eh	tor	Maryland Anne Arun	del Gle	n Burn	ie						1 ☐ Yes 2 ☑ No
	or 284	Director	10e. Street and Number			10f. Zip (Code		*******	10g. C	itizen of What Cou	ntry?
	ath w	rall	1321 Rippling Ct.			210			0.40		ted State	
36	be filed within 72 hours after death with the Maryland tal Hygiene d other then "naturel", or items 23s or 28s-f ehow event, the Medical Examinational be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 		was Decede If Yes, specif 1 Tes 2	fy Cubar	Spanic Origin , Mexican, F Specify:	n? (Specify Yes Puerto Rican, e	or No-	14. Race - Ameri Black, White, Specify: Whi	etc.
15-0036	72 hou		15. Decedent's Edu (Specify only highest grad	cation		dent's Usual kind of work			f working	16b.	Kind of Business/In	
N	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)		i working			
2	filed w Hygier other th	CO	12 17. Father's Name (First, Middle, Last)		Phone	Recep			Name (First, M		Answering	Service
au	og at b ≥	To Be	Joseph J. Nowicki						inna Por			
Maryland 21	s 1 and 2 should f 1ealth and Mer trem 27 is marks other traumatic	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street a				or Town, State, Zip	Code)
_	1 and 2 Health m 27 i		Mary Schneider / D								Maryland	
altimore,	Pages 1 nent of H int: If its		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ F	emoval nom State	lace of Dispo emetery, crer			1212	ril 13,		Location - City or To	
	permit. Pages Department of Important: If it any injury or o		4 □Donation 5 □ Other (Specify) 21. Signature of Fine I Service License	4	ly Ros				2006		ltimore,	
8	Dep de la company de la compan		1 total al		K 4	irkley 21 Cra	-Ruc in I	ldick lwy.,	Funeral S.E., C	Home,	P.A. irnie, MD	21061
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death	n. Do not ent	er the mode	of dying	, such as ca	rdiac or respira	tory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PNEUM	nia							Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequ								
		er	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	470 CQV uence of):		-					yen
/	cate be executed physicien and the burial-transit	Examiner	that initiated events	Asson	rel A	The.	me	ary	14			GEAS
Ö,	e exercien ar	Ex	resulting in death) Last	Due to (or as a consequ	uence of):							
8760	certificate be executed Iding physicien and Ise as the burial-transit	dlcal		i.								
Box	atter for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregna 1☐Live birth 2☐Fetal 4☐Pregnant at time of de	death 3	Ectopic pre					23d. Date of deliver	ery Day Year
a. O	by the destaction	hysi	9 Unknown	9□ Unknown								
Ś	signed be de	by	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying car	use give	n in Part I.	23e	Did tobacco	use contribute to to 2 No 3 Prot	
Record	0 - 0	Completed							_	Was an autopsy performed?	prior to co death?	psy findings available impletion of cause of
Vital R	ician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?						Death (Check	only one)		
6	Physi this c	- T	1 Yes 2 No	lospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time of		c loury	r: 4 🗆 Nursi		Residence	6 Other (Specif	(y)
Division	Attending Physician: r death. sctor: After this certific by the funeral director.	ertification:	1	(Month, Day Year)	Injury	м	c. Injury Work 1 Y	? es 2 □ No		ondo now my	ury occurred	
2	를 를 들	O	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	/)				City	or Town, Sta		
	he Hospital n 24 hours he Funeral bletely filled	edical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Exami	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death tion and/or in	n occurred at vestigation, i	t the time in my op	e, date and printed in the second printed in	place, and due occurred at the	to the cause(time, date ar	s) and manner as s nd place, and due to	tated. the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	1,0		I		number			ate signed (Month,	
•			Carses 4	Mouseer	- All	0 0	- 4	067	6/	1	nie 1	122006
	3		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)	me	will	a CA	REVE	N El	12006
	Sta		31. Date filed (Month, Day, ear)		ture	fr a	THE.	e 10	633 6	100		
	Registr	ar i	APR 1 3 2	JUG REGULE	A. A	304	,					

			For State Registrar	State of	f Marylan	•	rtment of H tificate of I	ealth and M Death		ene g. No. 0	6	11563
			1. Decedent's Name (First, Middle, Las	t)					2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Ezzatollah Rassek						April .	7, 2006	5	10:30 A M
	Examin	er	4a. Facility Name (If not institution, give Shady Grove Adven				4b. City, Town, or Rockvil	Location of Death		4c. County Montgo		
	Funeral Director		5. Social Security Number 6. S 240-84-2016	x Min 2□F	7. Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, October 28	Year) B, 1917	9. Birthp Cour Iran	
	ס		Usual Residence of Decedent		40- 0:5	Ŧ						Od Inside City Limite
	arylar show	_	10a. State 10b. County		10c. City	y, Town or Loc Rockv						0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the M	Directo	Maryland Montgom 10e. Street and Number	ery		KOCKV	10f. Zip Code	4	10	og. Citizen of V	Vhat Cour	
	Mith Ba or	ă	9701 Veirs Drive				20850			United		
	death	Funerai	11. Maritat Status	12. Was Dece	edent Ever in U.	S. 13. V	Vas Decedent of H	ispanic Origin? (Sp	ecity Yes or No-	14. Rac	e - Americ	can Indian,
20	be filed within 72 hours after death with the Maryland ital hygiene. d other then "neturel", or iteme 23a or 28s-f show event, I'm Medical Examinat must be notilised at	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2⊠No ⁄e		Yes 2⊠ No	Specify:	rican, etc.)	Specify	k, White, "Whi	
21215-0036	72 hor	ted	15. Decedent's Ec (Specify only highest gra			16a. Deced	ent's Usuat Occup	ation during most of work	una	16b. Kind of Bu	ısıne <i>s</i> s/în	dustry
N	ithin 7	Completed	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life. D	OO NOT use retired	()	9	D1		
	led willygien her th	Co	17. Father's Name (First, Middle, Last)	5+		Psyc	hiatrist	18. Mother's Nam	e (First, Middle, N		/sici	an
yland	12 should be filed within "n and Mental Hygiene. 7 ie marked other then "reumatic event, the Mer	To Be	Ahmad Rassekh						Mirzai	naiden Suman	<i>ie</i>)	
Mary	ss 1 and 2 should b of Health and Ments (Item 27 ie marked r other treumatice		19a. Informant's Name/Relationship (•	and Number or Run				
P.	and ealtl m 2		Dian Olson / Daug	hter	20h B			ook, Rock		aryland		
aitimore,	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State	rklawn	sition (Name of natory or other plac Memorial	Park 20	$^{11}_{06}$ 12 , R	ockvill	Le, M	laryland
Ball	20a. Method of Disposition 1 \$\mathbb{Z}\$ Burial 2 \(\text{Cremation} \) S \(\text{Other} \) (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rockville, Inc. M01433 Rockville, Mary1									umphre ntgome 1805	y Fui ry Av	neral Home/ venue,
	Physician		23a. Part1. Enter the disease, or com shock, or heart faiture. List only tmmediate Cause (Final		aused the deatl	h. Do not ente	er the mode of dyin					Approximate the trial Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	Spirato (or as a conseq	uence of):	1016					Iminute
	Examiner	L	Sequentially list conditions,		pSIS (r as a conseq	uanca of):					-	I week
	nsit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	70.	eumon	•						(week
Ď,	death certificate be executed e attending physicien and of for use as the buriat-transit		resulting in death) Last	Ü	(or as a conseq							
09/80	physicate by the t	dical		d								
ROX	eath certifi attending I I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1☐Live t	tcome of pregna	it death 3 🗆	Ectopic pregnancy	,			te of deliv	ery Day Year
o.	the dea y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregr 9☐Unkn	nant at time of d	eath 5□	Other (specify) _					
7	The law requires that the di ste has been signed by the bage 2 should be detached	þ	Part II. Other significant conditions of	ontributing to d	eath but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did tob	34		he cause of death?
Vital Hecords,	w requ	Completed							24a. Was a	n 24b.	Were auto	opsy findings available
ž	Physician: The law this certificete has al director, page 2:	Jmo:							autops perform	ned?	prior to co death? 1 □ Yes	ompletion of cause of
II	sian: artifice ctor. p	Bec	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only on	9)		
<u>></u>	hysic his ce il dire	٩	1 ☐ Yes 2 No			ER/Outpatien		4 Nursing H	ome 5 Reside			<i>fy</i>)
Ĕ	ling P After t unera	ion:	27. Manner of Death 1 Natural 5 Pending		of Injury th, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occur	red	
Division of	death death ctor: y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	9 380 Ptace	of Injury - At he	ome, farm, str	eet, factory, office	165 2 110	28f. Location (St.	reet and Numb	er or Run	al Route Number,
2	tel or Arsafter el Dire	Certification:	4 Homicide determined	build	ing, etc. (Specif	(y)			City or Town	i, State)		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example 1	niner: On the b	e best of my kno easis of examina ener stated.	owledge, death ation and/or inv	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the carred at the time, da	use(s) and ma ate and place,	anner as s and due t	itated. o the cause(s)
	Fo the Fo the comple	Me	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date signe	d (Month,	Day, Year)
			Produce	~ M	M		D004	3129		APRIL	712	006
	10		30. Name and address of person who POWLIMI NAD					rive, Roc	kville,	Marylaı	nd 20	1850
	Sta		W CAPA W W		Registrar's Signa	COLUMN DOOR	ecies					
	Regist	al		2	9	1						

06-02404	
Schmidt, Joyce	

Please Type or Print in Black Indelible Ink

nm	idt, Joyce		State : I- For S tate	of Maryland / Depar			Mental Hy	giene	2000	INECI.
	· · ·	_	Registrar		ificate of	Death		Reg. 2. Date of Death	No. 4000	3. Time of Death
edic	Physicia cal Examii	_	 Decedent's Name (First, Middle, Last Joyce M. Schmi 						ay Year	8:51
1	Jan 1970		4a. Facility Name (if not institution, give		41	o. City, Town, or L	ocation of Death	April 0, 2000	4c. County of Death	
			Baltimore Washington Med			Glen Burnie			Anne Arundel	
	Funeral Director		5. Social Security Number 6. Se 215-64-9643	F 2	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth (Cou	hplace (State or Foreign untry)
	<i>></i>		Usual Residence of Decedent	dos City T	own or Locatio		1			10d. Inside City Limits
	w an		10a. State 10b. County Ann	ne Arundel		" len Bur	nio			1 Yes 2 XXIVo
	yland 1-f sh	ţor	10e. Street and Number	le Alundei		10f. Zip Code	IIIE	10a	Citizen of What Cour	
	e Mar or 28; ied at	Director	122 South Bri	dae Drive 1		2106	:0	Tog.	USA	iti y i
	Editifiors, MD 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was	Decedent of Hisp s, specify Cuban,	anic Origin? (Spe		14. Race - Americ	can Indian, Black,
	ofter dear		3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 🗌	Yes 2XXNo	specify:		Specify ⁻	white
	2 hours a "natura LExami	Completed by	15. Decedent's Education (Specify on Elementary/Secondary (0-12)	ly highest grade completed)	luring	s Usual Occupation		ork done 1	6b. Kind of Business/l	ndustry
200	thin 7.	nple	12	0	most of w		maker		Own	HOme
5	ed wir Hygier other	S	17. Father's Name (First, Middle, Last)	O				First, Middle, Ma	iden Surname)	nome
5	be fill be fill cutal F rent, i	Be	Charles K. Bo	owen, Sr.				ie Poe		
ò	hould should and Me is ma	5	19a. Informant's Name/Relationship (T						er, City or Town, State	7 1 11611
2	md 2 salth a salth a sm 27		George J. Sch 20a. Method of Disposition		1	IZZ 5. ion (Name of cem			C A GIEN	Burnie MD
3	of He If it		1 Burial 2 Eremation 3	Removal from State Cre	ematory or other		- 1			
	UITI t. Pag tment rtant:		4 Donation 5 Other Specify:		1			11/2006	Daitim	ore MD
0	Dermi permi Depar Impo injur		21. Signature of Funeral Service Licen.	Victor		me and Address o Charles	_	evens F	Uneral H	ome
	Physician	1	23a. Part I. Enter the disease, or comp	ications that caused the death. I	Do not enter the	1501 E	uch as cardiac of	Avenue	Baltimo	reprinding 21,230
	/Medical		failure. List only one cause on ea	^{ch line.} Diltiazem intoxic						Between Onset and Death
	Examiner		1111	Due to (or as a consequence of)						
			Sequentially list conditions, b.							
		ine	cause. Enter Underlying Cause	Due to (or as a consequence of)						
	44	Examine	(I) isease or injury that initiated	Due to (or as a consequence of)						
	ate be executed thy sician and in burial - transit	E I	d.	د د د د د د د د د د د د د د د د د د د	27 20 ₂ £	norME -OF	= = /1 /Oc T	T		
	be exe	edical	X UNPENDED X	AMENDED item#23a,	2/ , 28a-1	,penul,geo	5,5/1/06 1	1		
1	LIVISION Of VITAL RECORDS, P.O. BOX 88/80, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearly. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnation Live birth Pregnant at time of dea	2 Feta	al death 3 [er (Specify)	Ectopic pregna	ncy	23d. Date of delivery Month	Day Year
	the des	Phy	Part II. Other significant conditions	9 Unknown contributing to death but not res	sulting in the ur	nderlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	s that th gned by	þ				, , ,		1 Yes	2 No 3 Prob	pably 4 Vunknown
	dS, equire een si	Completed						24a. Was an		topsy findings available
	COF law r has b	nple.						autopsy perform	ed? death?	completion of cause of
۱	The fficate	Š	05.111			00 Pl-++	of Dooth (Chook a	1 Yes 2	No 1 Y	es 2 No
	scerti	Be	25. Was case referred to medical examiner?	lospital: 1 🗸 Inpatient 2 🗀 I	ER/Outpatient		of Death (Check of Other: Nursing	-	esidence 6 Other	.
3	Phys Phys fer thi	<u>۲</u>	1 Yes 2 No 27. Manner of Death		28b. Time of th			28d. Describe ho		
	SION OT VITAL Attending Physician: r death: ector: After this certif by the funeral director.	ion	1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	unk	1 Y	es 2 X No	subject in	gested drug	
	JIVISION OF VITAL RECOPTOS, To the Ilospital or Attending Physician: The law requir within 24 hours after death: To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should the	Certification:	2 Accident Investigati 3 X Suicide 6 Could not	28e Place of Injury - At hor		, factory, office bu		28f. Location (Str.	eet and Number or Ru	ral Route Number, City
1	ital or ras afte	ertii	Suicide 6 Could not determined Homicide					or Town, Star Glen Burni	e) 122 South] e. MD	Bridge Dr
	Lospital Et hours of Funeral tely filled	a C	00- 0-4:5	an: To the best of my knowledge	e, death occurr	ed at the time, dat			•	ted.
	o the ithin o	Medical		On the basis of examination an and manner stated.	d/or investigati	on, in my opinion,	death occurred a	the time, date an	d place, and due to th	e cause(s)
	To To	Me	29b Signature and title of certifier			29c. License	number		29d Date signed (Mo.	nth, Day, Year)
			1 Offort ou	14)		O.C.N	1.E.	9	April 9, 2006	
	17		30 Name and address of person who	completed cause of death (Item 2	23a)					
	Ü		Laron Locke MD. Assis	tant Medical Examiner	111 Penn	Street, Baltim	ore, MD 212	01		
	C	tate	31. Date filed (Month, Day, Year)	32. Reistrar's Signatur	e /	alle "				

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

			For State Ragistrar		State of Ma	ıryland / Depa <i>Cei</i>	artment of He rtificate of De			ene 0 0 6	11565
	Physicia	an		e (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	/Medic			es T. S	*				April 1	12, 2006	4:20 a M
	Examin	er	,	Arist Ce	e street and number)		4b. City, Town, or Lo			4c. County of De	
	Funeral		5. Social Security N			(In yrs. last birthday)	If Under 1 Year I	f Under 24 Hrs.	8. Date of Birth	9. B	rthplace (State or Foreign
	Director		206-10-	9610 1	□M 2 ⊠. F	90 Yrs.	Months Days	Hours Min.	Month, Pay,	5/15 M	aryland
	pu »		Usual Residence o	f Decedent 10b. County		10c. City, Town or Lo	ecation				10d. fnside City Limits
	deeth with the Maryland me 23s or 28s-f show rmust be notified at	ō		ĺ ,							1 ☑ Yes 2 ☐ No
	28a-i	rect	Md 10e. Street and Nu	n/a		рал	ltimore 10f.ZipCode		10	og. Citizen of What C	Country?
	3a or	i Di	155 S.	Grundy	Street A	pt. 218	212	224		USA	
	deett	Funeral Director	11. Marital Status		12. Was Decedent E Armed Forces?	<u> </u>	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spi	ecify Yes or No-	14. Race - Arr Black, Wh	
20	n 72 hours after deeth with the Marylan "natural", or iteme 23a or 28a-1 show clost Examinar must be notified at	by Fu	1 ⊠ Never Marr 3 □ Widowed	ried 2 Married	1 ☐ Yes 2 ☐ N If Yes, Give	lo		Specify:	riidari, oto.,	Specific	
2-003e	tural		2 - AAIGGMAG	15. Decedent's E	Year or Dates:	16a. Dece	dent's Usual Occupation	on		6b. Kind of Busines	White
<u>ე</u>	within 72 ene. than "na! ne Medic	Completed	(Spec	cify only highest gra	de completed) College (1-4or 5	(Give	kind of work done dur DO NOT use retired)	ing most of work	ing		,
7		Com	7		0		embler			Westin	ghouse
	d is a S	Be		(First, Middle, Last,)		18		e (First, Middle, N beth Zi		
ylan	2 should be and Mental is marked aumatic ev	P		Sponar	Time Driet	105 Mailie	ng Address (Street and				Zin Codel
<u> </u>	D = 1 = 1			_{ame/Relationship (} seph Cho			Chestnu				
อ์	s 1 and 2 should t Health and Men Item 27 is marke other traumatic		20a. Method of Dis		vali		esition (Name of matory or other place)			20c. Location - City of	
Ē	Pages ent of nt: if i			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State	1	nislaus	4/1	8/06 I	Baltimor	e. Md.
Baitimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 eny Injury or other ODGE.		21. Signature of Fo	neral Service Lice	1588		A CZTT AWSK				7 1141
מ	88188	11	Cug	ene J.	Certr	700	201 Dunda				d. 21222
			shock, or hea	art failure. List only	plications that caused one cause on each lin	10.	, ,			st,	Approximate fnterval Between Onset and Death
	Physician		Immediate Cause disease or condition resulting in death)	on	a		renal	+AiL	UVE		week
	/Medical Examiner		rooming in doubly	- (a consequence of):	Artery	Cle-a		. 1	
	- A	ler	Sequentially list co	onditions, nmediate	b	a consequence of):	,,,,,,	37 -7	rome		
	cuted nd ransit	Examiner	cause. Enter Under Cause (Disease or that initiated event	s 🔳	c	Se	psis s	Synd	rome		wella
Š	e exerien at	I Ex	resulting in death)	Last	Due to (or as a	a consequence of):					
09/8	ificate be executed g physicien and as the burial-transit	edical		•	d			_			
Š O	ding ise as		fF FEMALE:		23c. ff yes, outcome	of pregnancy				23d. Date of d	alivary
X POX	res that the death certifighted by the attending be detached for use a	Physician/M	in the past 12	months?	1⊡Live birth 4⊡Pregnant at	2 Fetaf death 3	Ectopic pregnancy Other (specify)			Month	Day Year
5	by the	hys	9 Unknow	*	9∐ Unknown						
	es the	by F	Part II. Other signi	ficant conditions	contributing to death bu	ut not resulting in the u	nderlying cause given	in Part I.		-	to the cause of death?
ecords,	w require been sig should b	eted							1 □ Ye		Probably 4 Unknown
Hec	e la has je 2	Completed							24a. Was ar autopsy perform	/ prior to	autopsy findings available completion of cause of
		e Co	25. Was case refe	read to madical	5700 - 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1	- in			1 ☐ Yes 2	No 1 □ Ye	s 2 125 No
Vital	rsician: s certific director,	0	examiner?		Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatier	Other		h <i>Check</i> only one ome 5 □ Reside	nce 6 ther (Sp	ecity) Hospice
O	ding Phys th. Atter this of funeral dir	T:u	27. Manner of Dea	th	28a. Date of Injui (Month, Da)	y 28b. Time o			28d. Describe ho		7
200	ttendin death. for: Alt the fur	atio	1 XNatural 2 Accident	5 Pending investigatio	n	, out,		s 2□No			
DIVISION	or Att	ertification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or i , State)	Rural Route Number,
_	spital ours a neral [O	29a. Certifier	1X Certifying Pi	nysician: To the best of	of my knowledge, deat	h occurred at the time.	date and place	and due to the ca	use(s) and manner	as stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	(Check only one)		miner: On the basis of and manner sta	examination and/or in					
	To the To the Comp	ž	29b. Signature and	title of certifier	10		29c. License n	number	29	od. Date signed (Mo	nth, Day, Year)
			1	Kith	my kil	J. MD	1743	001	/	161.01	2, 2006
			30. Name Ind add	ress of person who	com leted cause of the	a h (Item 23a) (Type,	Print) N. Ch	ules J	1. Ba	lts. ma	71204
	Sta	ite	31. Date filed (Mor	·		ar's Signature	£				
	Registr	ar		APR 1 3 2	006 100	as the pop	to the same				

			For State	State of M		nd / Dep	artment of	Health and	-	•	gible. 0.6	11566
			Registrar Decedent's Name (First, Middle, Las	*1		Ce	rtificate o	Death		Reg. No.		
	Physici /Medi		Lucille Elizabeth	Schaefer					2. Date of De Month	Day	Year	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution, give) i l = -	- 1	4b. City, Town,	or Location of Dea	th	4c. Cour	nty of Death	
			5. Social Security Number 6. So	LUCRE	105	last birthday	If Under 1 Yea	F Claute	2 D (D)		THIM	ORE
	Funeral Director			m m =	83	Yrs.	Months Day			1923	Maryl	lace (State or Foreign try) and
3	aryland ahow		10a. State 10b. County		10c. Ci	ty, Town or L	ocation				10	Od. Inside City Limits
	≥ 13	ō	Maryland Baltimon	~e	Ro	sedale						1 ☐ Yes 2 🛣 No
(1)	with the M is or 28a-f	rec	10e. Street and Number		110	ocaaic	10f. Zip Code			10g. Citizen o	of What Count	try?
\Box	= 23 ≡	Funeral Director	9 Caterham Court				2123	57		Unite	d Stat	es
	8 5	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U	.S. 13.	Was Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No	- 14. R	ace - America lack, White, e	an Indian,
386	hours after tural', or ite	þ	1 ☐ Never Mamied 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates:	χ No		1 ☐ Yes 2 🗓 N		io riiodri, oto.)		cify: Whit	
LULC 215-0036	72 hor	To Be Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usual Occ	upation e during most of wo	prkina	16b. Kind of	Business/Ind	lustry
	within 9ne. then '	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retii	red)	3	0	**	
4 5 P	e filed Il Hygie other	ပ္တို	12 years 17. Father's Name (First, Middle, Last)	n/a		Homem	акег	18. Mother's Na	me (First, Middle	Own		
OEFER Maryland 21	iges 1 and 2 should be filed within of Health and Mental Hygiene. If Itam 27 is marked other than or other traumatic avent, the Mental Cavent, the Mental Cavent	o B	Richard Leutner					Florence		, maider our	ame/	
可义	2 should be and Mental is marked aumatic av	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Maili	ng Address (Stree	et and Number or R		er, City or Tow	m, State, Zip	Code)
	alth a		Richard G. Schaefe	er (son)				t. BAltim				10.7
Z e	of Hea of Hea of Hea of Hea of Heam rothe		20a. Method of Disposition	D	20b. F		osition (Name of matory or other p		Date		n - City or Tov	wn, State
Saltimore,	permit. Pages Department of Important: If i any Injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify					Pk. 4-13	3-2006	Elkrid	ge, Ma	ryland
3at ()	permit. Departimport any inj	١.,	21. Igna velot Fundral Serve Licen	see Nayne Oste	orlin	M	2. Name and Add	ress of Facility Olyniak F	uneral H	lome. P	A	
	₫ Q E € Q					2	3/ E. Pa	tapsco Av	e. Balti	more.	Maryla:	nd 21225
			23a. Part1. Enter the disease, or composhock, or hear failure. List only	olications that cause one cause on each	d the deat line.	h. Do not en	ter the mode of dy	ring, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Rest	SIRO	tory	Park	irt				Onset and Death
	Examiner			Due to (or a	s a conseq	juence of):	1:2:	~ ^ E		31.		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t (or a	s a conseq	uence of):	tivity	Duc	umon	142		
1/	executed in and ial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	PALE	FLLY	noni	0. 1					
0,	e be executed sicien and s burial-transit		resulting in death) Last	Due to (or as	s a conseq	uence of):						
8760,	ate be hysicie the bur	lcal		d								
Вох 68	The law requires that the death certificate is the been signed by the ettending physicage 2 should be deteched for use as the	Physician/Medic	IF FEMALE:	03- 16								
Bo	ettenc for us	lan	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3	Ectopic pregnan	су			Date of deliver	ry Day Year
P.O.	thet the de ed by the deteched	yslo	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	at time of u	ieaui 5	Other (specify)					,
٠,	res thet igned b be dete	y Pt	Part II. Other significant conditions co	ontributing to death	but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did to	obacco use co	intribute to the	e cause of death?
rds	w require been sig should b	Completed by	ileus abo	domina	10	diste	ntion		10	Yes 2 X No	3 🗌 Proba	abiy 4 Unknown
ဝင္	ne law requ hes been ge 2 shoulk	plet	BEVERE di	SDlag	in.	ک			24a. Was	an 24b	. Were autop	sy findings available
Ř		ĕ		1						rmed?	death?	npletion of cause of 2 1 No
Division of Vital Records,	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?						ath (Check only o			
of.	Physic this c	မှ	10 163 22 140	Hospital: 1 X Inpati		ER/Outpatier	IL 3 DOA		Home 5 ☐ Resid)
n C	ding f	lo Lo	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Inj (Month, D.	ury ay Year)	28b. Time o Injury	W		28d. Describe I	now injury occi	urred	
isi	death death ctor: y the	licat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of In	niury - At h	nme farm st	reet, factory, office]Yes 2 □No	28f. Location (S	Street and Nur	nhar as Pusal	Pouto Mumbos
ē	effer Dira d in b	Certification:	4 Homicide determined	building, e	tc. (Specif	(y)	dot, factory, office		City or Tox	vn, State)	iber or nurar	noute wantber,
	ospitu hours unera ly fille		29a. Certifier 1(∑ Certifying Phy (Check only 2 ☐ Medical Exam	ysician: To the best	t of my kno	wiedge, deat	h occurred at the	time, date and place	e, and due to the	cause(s) and r	nanner as sta	ated.
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	one)	and manner s	or examina	ttion and/or in	vestigation, in my	opinion, death occ	urred at the time,	date and place	and due to	the cause(s)
	To T	2	29b. Signature and title of certifier		1		29c. Licer	nse number		29d. Date sign	ned (Month, D	Day, Year)
	~		Man	ia se	e L	MD		5£500	0	4/10	106	
	12		30. Name and address of person who o	completed cause of	O	23a) (Type,	Print)		~			21237
	Sta	10	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	UUO	TKOD	KLID	og uall	= 175°	Rathe	nore MD
	Registr			er.	g-10		() () () () ()		•			
DH	IMH 17 Rev 1/2	001	APR 1 3 200	6 Sees	2	- 100	HE .					
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			For State Registrar	State of	f Man	yland / Dep <i>Ce</i>	artmen rtificat			and M		giene Reg. No.	11116	11567
614	Physici	20	1. Decedent's Name (First, Middle			ID.					2. Date of Dea		06 Year	3. Time of Death
	/Medic				VE, S	6K •	4h Ch	Tour or	Location o		AI KILI O		County of Dea	3:48 A M
13	Examin	er	4a. Facility Name (If not institution 529 Sylview D	_	прег			Pasa		or Death		An	ne Aru	ndel County
76	Funeral Director		5. Social Security Number 214-40-6946	6. Sex 1 ☑ M 2 ☐ F	7. Age (I	n yrs. last birthday 64 Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth Month, Day Dec. 0	4,19	41 Mai	thplace (State or Foreign ountry) ryland
	pug *		Usual Residence of Decedent 10a. State 10b. County		10	Dc. City, Town or L	ocation							10d. Inside City Limits
	Maryla	io		Arundel		Pasaden	а							1 □Yes 2 ☑No
	r 28a	Directo	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What C	ountry?
	ith wit	al D	529 Sylview Dri	ve				211:					U.S.A	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 le marked other than "natural", or itema 23a or 28a-f ehow important: If item 27 le marked other than "natural", or itema 23a or 28a-f ehow yi injury or other traumatic event, the Medical Exercities roual by notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 ☑ vorced	If Yes G	rces? 2 ☑•No ve	er in U.S. 13.	Was Deced If Yes, special 1 Yes)	ispanic Ori in, Mexican Specify:	gin? (Spi i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify:	
5-0	72 hc	eted	15. Deceder (Specify only highe	it's Education st grade completed;		16a. Deci (Giv	edent's Usua e kind of wo DO NOT u	al Occupa	ation during mos	t of work	ing	16b. Kir	nd of Business	/Industry
121	within and the within within and within a within and within a	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Build		1)				Calf.E.	nn1 ovod
	filed v Hygie other f	e Co	17. Father's Name (First, Middle,	Last) N/A			DUITU	er	18. Mothe	er's Name	e (First, Middle,			mployed
Maryland	should be nd Mental marked o	ToB	Unknown						De1	ores			Ç	Szydowski
dan	2 sho		19a. Informant's Name/Relations								al Route Numbe			
	1 and lealth om 27 ther to		George W. Sto	ne, Jr. (20b. Place of Disc	osition (Nai	me of			asadena Date		ryland	
nor	Pages nent of P ant: If its ury or of		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		State	Bayview				4-10	-06			, Maryland
Baltimore,	permit. P Departme Importan any injur		21. Signature of Funeral Service			-		-	1		1			nd 21122
*		l)	23a, Party. Enter the disease, o shock, or heart failure. Lis	only one cause on	ach line	e death. Do not e	nter the mod	de of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Comy one sause on	=5	sonsequence of):	09 R	0/		a	100-	_		Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a c	onsequence of):	1							
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	ate be executed nysician and he burial-transit	Examiner	that initiated events	S c										
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6876	cate b physic	dicai		d										
Вох	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No		ointh 2 [nant at tin	Fetal death 3	□Ectopic p □ Other (sp		′			2	23d. Date of de Month	elivery Day Year
P.O.	hat the od by the detach		9 Unknown Part II. Other significant conditi			not resulting in the	underlying (CAUSA DIV	en in Part I		23e. Did to	obacco u	se contribute	to the cause of death?
Records,	uires t n signe ud be o	Completed by		•				3			X	es 2[□No 3□F	Probably 4 Unknown
CO		plete									24a. Was		24b. Were a	utopsy findings available
- R	The I	Hoo									perfo	rnoed? 2 No	death?	completion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospitali				Oth	05		h (Check only o	ne)		
ō	ding Phys h. After this c funeral dir	- To	1 Yes 2 No 27. Manner of Death	28a. Date		2 ER/Outpatie		28c. Injun Wor	4 🗀 190	ırsing Ho	me 5 Resident		6 □Other (Sp y occurred	ecify)
ion	Attending r death. ector: Alter	ation	Natural 5 Pendi 2 Accident invest	ng (Moi igation	ith, Day Y	(ear) Injury	М		k? Yes 2□	No				
Division	r Atte ter des irector	rtific	3 Suicide 6 Could 4 Homicide deter	nined 288. Place	of Injury	- At home, farm, s	treet, factor	y, office			28f. Location (S City or Tox			Rural Route Number,
	pital o	Ce	29a. Certifier 1 Certifyi	ng Physicien: To th	a best of a	my knowledge, dea	ith occurred	Lat the tin	no date ar	nd place	and due to the	Cause(s)	and manner	as stated
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	(Check only Medica one)	Exeminer: On the	asis of e	camination and/or	nvestigation	n, in my o	pinion, dea	ith occur	red at the time,	date and	I place, and du	e to the cause(s)
	Vithin To the	Σ	29b. Signature and title of certific	er / 1	-	ano	29		e number	8				oth, Day, Year)
	10		30. Name and address of person	who completed car	se of dea		Print).	12	117	0	/	1/20	1 /	0,2006
	50		795 6	quah	ar7	Ro	od i	61	26	15	Conie	h	0 2	106/
77.	Sta Regist		31. Date filed (Month, Day, Year	SV.	idgistrar's	Signature	will be							
	ricgist	4-17	APR 1 3	2006		~ //								

			Please T	ype or Print in Blac State of Maryland /	Depa		lealth and N	Mental Hy	giene 🕕 🕕 (
,			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	runcate of	Dealii	2. Date of De	Reg. No.	3. Time of Death
	Physicia /Medic		WILLIAM	FREDERICK	SAU	NDERS II	I	APRIL		12:35 P M
	Examin	40	4a. Facility Name (If not institution, give s 1631 Clarkson S			4b. City, Town, o	r Location of Death		4c. County of n/a	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral Director		5, Social Security Number 6. Sex		irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov. 2	th year) 9 4,1945	Birthplace (State or Foreign Country) Ohio
land	MO N		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	ocation				10d. Inside City Limits
e Man	Sa-f eh	ctor	Maryland n/a		Ba1t	imore				1 XYes 2 No
h with th	3a or 2	al Director	10e. Street and Number 1631 Clarkson Str	eet		10f. Zip Code 21230			10g. Citizen of Wha United St	•
.0036 hours after death with the Maryland	ital Hygiene. d other then "natural", or items 23s or 28s-1 ehow event, the Mwalical Exemination at the notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. am	Was Decedent of Hilf Yes, specify Cub. 1 ☐ Yes 2 No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
15-CL	"nature Mulical E	Completed	15. Decedent's Educ (Specify only highest grade	completed)	a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	ation during most of work d)	cing	16b. Kind of Busin	ness/Industry
-C1212 b	giene.	Comp	Elementary/Secondary (0-12) 12 years 5	+ years	E1e	evator Me				r Repair
and	ental Hygis ked other c event, II	To Be C	17. Father's Name (First, Middle, Last) William Frederick	Saunders, Jr.			18. Mother's Nam Frances		, Maiden Sumame) gton	
, C	of Health and Mental I	1	19a. Informant's Name/Relationship (Type Kathleen C. Saunde	00, Print) 19			and Number or Ru St. Balt		er, City or Town, Sta MD 21230	ate, Zip Code)
Baltimore, IV	or other		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ R	emoval from State cemet	ery, cre	osition (Name of matory or other pla en Mem. P		Date 2006	20c. Location - Ci	ty or Town, State
	Department of Pimportant: if Ite eny injury or of once.		4 □ Donation 5 □ Other (Specify) 21. Sign or of unetal Service Lines	98	Me	2. Name and Addre	ss of Facility	neral H	lome. P.A.	
	40 = 90			Wayne Osterling cations that caused the death. Do cause on each line.	-1.	30 E. For	t Ave. Ba	iltimore	, MD 2123	Approximate
100	hysician /Medical xaminer	Je.	Immediate Cause (Final disease or condition resulting in death)		_ 0 l		anter			Interval Between Onset and Death
68760, <		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):					
Records, P.O. Box 687	y the attending piched for use as	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	,
ds, P	been signed by the should be detached		Part II. Other significant conditions cor	tributing to death but not resulting	in the u	inderlying cause gr	ven in Part I.			ute to the cause of death?
Division of Vital Records,	ete has beer page 2 shou	Completed						24a. Was auto perfe 1 🗆 Yes	psy pric	ore autopsy findings available or to completion of cause of ath?
Vita	sertific ector,	Be	25. Was case referred to medical examiner?	lospital:		0"	26. Place of Dea			
nof	Merthis o	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 EP/C	Outpatie . Time c Injury	of 28c. Inju	ry at rk?		idence 6 Other how injury occurred	
Division of Vital	within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, st		Yes 2□No	28f. Location ((Street and Number wn, State)	or Rural Route Number,
Li dice	within 24 hours after death To the Funeral Director: completely filled in by the		(Check only 2 Medical Exami	fician. To the best of my knowled ner: On the basis of examination a	ge, deal and/or ir	th occurred at the ti	me, data and place opinion, death occu	, and due to the rred at the time,	causa(s) and mann date and place, and	or as stated. d due to the cause(s)
1	within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licen		\	29d. Date signed (1.
1	+1		30. Name and address of person who co		ı) (Type	. Print)	24085		4/5	12006
6	, ,		31. Date filed (Month, Day, Year)	32. Sqistrar's Signature	3	01 >4, 1	nol Place	15,1	Ji-ore	21303
	Sta Regist		4.00	006 Been &	4	met l				

DHMH 17 Rev 1/2001

		For State Registrar	State of Maryland	d / Department Certificate		_	Hygiene Reg. No.			
	Dharinin	1. Decedent's Name (First, Middle, La	est)			2. Date of Death Month	Day Year	3. Time of Death		
	Physician /Medical	TAROV		SMOLENSK		APRIL 1		11:15 A M		
	Examine				own, or Location of Death		4c. County of Death	TIMORE		
	Funeral		Sex 7. Age (In yrs. I	ast birthday) If Under 1		8. Date of Birth		place (State or Foreign intry)		
	Director	217-27-7949	¹ X ^{M 2□ F} 81	Yrs. Months I	Days Hours Min.	Month, Day, Yo 02/15/192	5	RUSSIA		
	and *	Usual Residence of Decedent 10a. State 10b. County	10c. City	/, Town or Location				10d. Inside City Limits		
	Maryti	MD	N/A BAL	TIMORE				1 X □Yes 2□No		
	vith the Mar or 28a-f ai	10e. Street and Number		10f. Zip C	ode	10g	. Citizen of What Cou	intry?		
	th with	3211 CLARKS LANE	APT.#221	21	.215		U.S.A			
	or iteme 23a	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🔊 No	S. 13. Was Deceder	nt of Hispanic Origin? (Spe / Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
36	al', or i	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2	No Specify:		Specify:	WHITE		
21215-0036	within 72 hours after death with the Maryland ene. then "natural, or iteme 23s or 28s-f show the Modical Examinar must be notified at the modical hy European Director		ducation	16a. Decedent's Usual	Occupation done during most of worki	16	b. Kind of Business/li			
215	ygiene." naturi ri, ine Medical i	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	retired)		UTOMOBILE			
121	Hygier thent.			ENGINEER	18 Mother's Name	(First, Middle, Ma				
and	d be fi	I NAVD		LENSKY	SARAH	(mai, maara, ma		NKNOWN		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Menial Hygiene. Item 27 is marked other then "natural; or iteme 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at To Be Completed by Europea Director	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street and Number or Rura	Al Route Number, C	City or Town, State, Zi	ip Code)		
	1 and 2 Health a tem 27 is	YELENA SMOLENSKA	AYA/DAUGHTER	6905 JONES	VIEW DR. U		BALTIMORE	MD 21209		
altimore,	of He of He if item	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [I ^	lace of Disposition (Name emetery, crematory or oth		Date 20	c. Location - City or T	own, State		
Ë	Pages tment of tant: If it ijury or o	4 □Donation 5 □ Other (Spec	ity) BAL		W CONG 04/12	2/2006 R	EISTERSTO	N, MD		
Bal	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.	21. Signature of Funeral Service Lice	nsee CIHO.				N & BROS.	THE CONTRACT		
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death	n. Do not enter the mode	ISTERSTOWN F of dying, such as cardiac of	ROAD - PI or respiratory arrest	KESVILLE,	MD 21208 Approximate		
	Physician	shock, or heart failure. List only Immediate Cause (Final disease or condition	1					Interval Between Onset and Death		
	Physician /Medical	disease or condition resulting in death)	Due to (or as a consequence	uence of):				montas		
	Examiner	Sequentially list conditions	b							
	po #	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uenes of).						
3	and and II-tran	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	uence of):						
092	p price	Cal	. d							
68	certificate iding physise as the									
ος Box	that the death certifically be by the ettending place be for use as the by the control of the co	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Feta		nancy		23d. Date of deli	,		
) : (e deal	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time of de 9☐ Unknown				Month	Day Year		
μ. P.	that the		contributing to death but not res	ulting in the underlying cau	use given in Part I.	23e. Did toba	cco use contribute to	the cause of death?		
ds,	8 <u>6</u> 8	â			3	1/X Yes	2 □ No 3 □ Pro	bably 4 Unknown		
Record	2 0 50					24a. Was an	24b. Were au	topsy findings available		
Be 2	The la	d				autopsy performe 1 ☐ Yes 2	d? death?	ompletion of cause of 2 ☐ No		
ita	ien: 1	25. Was case referred to medical			26. Place of Deatl	h (Check only one)				
12 × 2	Physicien: this certific ral director,	O 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐				ce 6 Other (Spec	in hospice		
127/ on 0	th. After to funera	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28 Injury M	c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred	•		
molens/27 Unision of Vital	death ctor: y the	2 Accident investigati 3 Suicide 6 Could not	be 390 Place of laius. At he			28f. Location (Stre	et and Number or Ru	ral Route Number,		
Smolens/ Division o	after Dire	27. Manner of Death Natural 5 Pending	building, etc. (Specif			City or Town,	State)			
01	To the Hospitel or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2)	29a. Certifier (Check only 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina							
	thin 2 the It mplet	one) 29b. Signature and title of certifier	and manner stated.	29c.	License number	290	I. Date signed (Monti	1. Dav. Year)		
	To Con	Maran	Lins	0	(8302	A	PAIL 1/11	206		
	2	30. Name and address of person wh	o completed cause of death (Item	n 23a) (Type, Print)	0. 1	,	7.001 1100			
	0		Charles ins	6601 N-CC	SESU3	source	mo 2120	/		
	State	40012	32. Figistrar's Signa	ature South						
	Registra	WLV T 9	COOO CONTRACTOR							

			1 - State of Ma State Registrar	ryland / Depa <i>Cer</i>	artment of H			2006	1571
	Dharisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medio		Joseph William Su	ryder				1 2006	11:00 PM
	Examin	er	4a. Fecility Name (If not institution, give street and number) Novethwest Hospital		**	r Location of Death よりいん	^	4c. County of Death Baltime	
	Funeral Director			(In yrs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cou	place (State or Foreign ntry)
	ס		Usual Residence of Decedent				03/21/19		
	ehov	7	10a. State 10b. County MD BALTIMORE	10c. City, Town or Loc BALT					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the N	ect	10e. Street and Number	DALTI	10f. Zip Code		100	. Citizen of What Cou	
	th with	al Di	3114 LIGHTFOOT DRIVE		21208			U.S.	•
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If Item 27 is marked other than "naturel", or Items 23a or 28e-f ehow or other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 N H Yes, Give X Year or Dates:	0 11	Was Decedent of H f Yes, specify Cuba I □ Yes 2 ☑ No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occup kind of work done of OO NOT use retired	during most of work	ing 16	b. Kind of Business/Ir	ndustry
12	withir lene. r than	ошо	Elementary/Secondary (0-12) College (1-4or 5-	OWNER		",	BAI	LTIMORE DI	SPLAY
ğ	other	Be C	17. Father's Name (First, Middle, Last)	0		18. Mother's Nam	e (First, Middle, Ma		OT LIVE
ylar	should be ind Mental marked o umatic eve	To	DAVID	SN	NYDER	ESTHER		K	LEIN
Maryland 21215-0036	nd 2 shallth and 27 is m		19a. Informant's Name/Relationship (Type, Print) FLORENCE SNYDER / WIFE		-			City or Town, State, Zi, ORE, MD 21	
Baltimore,	permit. Pages 1 a Depertment of Hes Important: If Item any Injury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispose cometery, crem	sition (Name of natory or other plac ERVICE CO	ÖRP. 04/1	2/2006 TO	c. Location - City or T	own, State
Balt	permit. Depertrimports any Inji		21. Signature of Funeral Service Licegsee		Name and Addres	. 20		ON & BROS. IKESVILLE.	, INC. MD 21208
ı			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente					Approximate Interval Between Onset and Death
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	•	Criset and Death				
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	D #	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					
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8760,	cate be executed obysicien and the burial-transit	dical E	d.						
9		Medi	IF FEMALE:					I	
.O. Box	The law requires that the death certificate hes been signed by the ettending page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnanl in the past 12 months? 1 Yes 2 No 9 Unknown	2 ☐ Felal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
<u>α</u>	uires that it signed by	d by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the un	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	
Vital Records,	The faw requiri e hes been si age 2 should I	Completed					24a. Was an autopsy performe	24b. Were aule prior to co death?	opsy findings available impletion of cause of
ita	lan: rtifice	BeC	25. Was case referred to medical			26. Place of Deat	1 ☐ Yes 2/2 h (Check only one)	No 1 ☐ Yes	2 LI NO
<u>×</u>	hysic his ce I direc	To	examiner? 1 Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpatient		4 Linuising no	me 5 Residence	ce 6 □Other (Speci	fy)
N C	iling P t. After t funera	lon:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe how	injury occurred	
Division of	for Attending Physician: after death. Director: After this certific I in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju building, etc.	ry - At home, farm, stre (Specify)		Tes ZINO	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
י	Hospita 4 hours Funeral	Medical Ce	29a. Certifier (Check only Medical Examiner: On the basis of	examination and/or inv	occurred at the time	ne, date and place, pinion, death occur	and due to the caus	se(s) and manner as s	stated. o the cause(s)
	To the within 2 To the complet	Med	one) and manner state 29b. Signature and title of certifier		29c. License		29d	. Date signed (Month,	Dey, Year)
	. *		I Jamelan A. Yora			PP0 25	Ap	ril 11 2000	
	10		30. Name and address of person who completed cause of de Jenniter Yorke 20 540	ath (Item 23a) (Type, I Cld Cookt	Print) Rd Ro	undallstoc	on mo	21133.	
	Sta			r's Signature					
	Registr	ar	APR 1 3 2006	. 15 ADO	West -				

DHMH 17 Rev 1/2001

ORIGINAL

			State of Marylan							1	gible.	1 1 1000 807 80
			1 - State Registrar	Cer	tificate	of D	eath		-	No.U	U 6	11572
. *	Physicia	an	1. Decedent's Name (First, Middle, Last)					N	ate of Death Ionth	Day	Year	3. Time of Death
	/Medic	al	VIRNIA ODESSA STARR 4a. Facility Name (If not institution, give street and number)		4b. City, To	wn. or L	ocation of		pril		2006 nty of Death	3:32 PM
-	Examin	er	Southern Maryland Hospital				y, MI			PG		
2	Funeral Director	2520	5. Social Security Number 577-24-1507 6. Sex 1 □ M 2 □ F 85	ast birthday) Yrs.	If Under 1		lf Under 2 Hours	Min. (A	ate of Birth Month, Day, Y		Cou	place (State or Foreign ntry) er, S.C.
	D		Usual Residence of Decedent	, Town or Lo				p ur.	C 1/,	1720		10d. Inside City Limits
	Aarylau show	ō		ndover								¹X Yes 2 □ No
	r 28a-	Director	10e. Street and Number		10f. Zip C	ode			100	ı. Citizen (of What Cou	intry?
	23e o		7720 Nalley Court		207					USA		
	er dea	une	11, Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Deceder f Yes, specify	nt of Hisp Cuban,	anic Orig Mexican,	in? (Specify) , Puerto Ricar	res or No- n, etc.)		Race - Ameri Black, White	
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or fleme 23e or 28e-f show ent, the Masical Examiner man be notified a	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 □ Yes 2]	Ŭ No	Specify:			Spe	cify: B	lack
5-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual (kind of work DO NOT use	Occupati done dui	on ring most	of working	16	ib. Kind of	f Business/Ir	ndustry
72	withir liene.	omo	Elementary/Secondary (0-12) College (1-4or 5+)		Server					Fede	ral G	overnment
b	al Hyg al Hyg a othe	Be C	17. Father's Name (First, Middle, Last)					r's Name (Firs		iden Surr	name)	
yla	d Ment narked natic	2	George Anderson	10h Maitir	a Address /			ie Blai ror <i>Rural R</i> ou		Situat Tou	ım State 7i	in Code)
Mai	nd 2 stallth and 27 is n		19a. Informant's Name/Relationship <i>(Type, Print)</i> Regina Starr Holman/Daughter		-			Landov			785	p code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural; or Iteme 23e or 28a-1 show any injury or other traumatic event, the Madical Examiner mant be multiled at an		1 Liburial 2 Licremation 3 Linemoval from State		natory or other			Date			on - City or T	
豆豆	int. Parament.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 7	•	lemoria						er, M	me, Inc.
Ba	Department of the permitted of the permi		Neshaun Walto									, DC 20001
			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	_								Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ATHEROSC Due to (or as a conseq		TIC C	ARI	DIOVA	as Cul	AR D	iser	SE	
1	Examiner			uonos ory.								
	led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):								
(C	be executed ician and burial-transit		that initiated events resulting in death) Last C. Due to (or as a conseq	uence of):								
8760,	y s	lical	d									
89 x	certific nding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnant 25c. If yes, outcome 25c. If yes, out	ıncy						23d.	Date of deliv	very
Box	death ed for i	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☑ No 1 ☐ He past 12 months? 4 ☐ Pregnant at time of d		□Ectopic preg □ Other (spec						Month	Day Year
P.O.	that the di ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cau	ise diveu	in Part I.		23e. Did toba	cco use c	ontribute to	the cause of death?
Division of Vital Records,	law requires that the death certifica as been signed by the attending ph . 2 should be detached for use as it	ed by	HYPERTENSION DIABO					15	1 ☐ Yes	2 🗆 No	3 ☐ Pro	bably 4 Munknown
eco	ne law re has bee ge 2 sho	Completed	GASTRO INTESTIMAL HE						24a. Was an autopsy		prior to c	topsy findings available ompletion of cause of
al B	Thate The		00,10	1771	URE				performe	No	death?	2 🗆 No
Z.	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA			of Death (Ch rsing Home			Other (Spec	erfy)
n o	ding Phys h. After this (funeral dir	on; T	27. Manner of Death 1 ☐ Matural 5 ☐ Pending (Month, Day Year)	28b. Time o Injury	of 280	c. Injury a Work?	,		Describe how	injury oc	curred	
isio	Attendii death. ctor: A y the fu	Ilcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury. At h	ome, farm, st	M reet, factory,		es 2 🔲 t		ocation (Stre	et and Nu	ımber or Ru	ral Route Number,
Ö	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune	Certification;	4 Homicide determined building, etc. (Specif	y)					City or Town,	State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check outly one) 1 Certifying Physician: To the best of my known one) 1 Medical Examiner: On the basis of examination and manner stated.	wledge, deat ition and/or in	h occurred at vestigation, in	the time n my opii	n, date and nion, deat	d place, and o th occurred at	fue to the cau the time, dat	ise(s) and e and plac	manner as ce, and due	stated. to the cause(s)
	To the within To the Comp	Ň	29b. Signature and title of certifier	Hue.c.	29c.	License	number	12.17	29	•	ned (Month	n, Day, Year)
Ţ	2		30. Name and address of person who completed cause of death (Iter	n 23a) (Tvna	Print)	ンニ	الانكار					
_			8700 CENTRAL AV H301, LA	NDOV	62,	MI	2	20785	>			
	Sta Regist		30. Name and address of person who completed cause of death (Iter 8700 CANTAL AV + 301, LA 31. Date filled (Month, Day, Year) APR 1 3 2006	ature &	Spanie	V						

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 1 3 2006

Registrar's Signature.

Registrar's Signature

cause of death (Item 23a) (Type, Print)

PRULY

21043

		ı	For 1 State	State of Marylar	•				0.0	106	11571.
	-		- State RegistrarAmend Item 1 1. Decedent's Name (First, Middle, Last,	9 Per Ana Bd	g854°	1713906°U	H Call	2. Date of Dea		100	3. Time of Death
	Physici /Medio		MARY IRENE	SMITI	L			Month 3	Day 31	- 06	10 45 PM
	Examir	er	4a. Facility Name (If not institution, give			FREDEP	Location of Death	า้อ		ounty of Death	lc K
	Funcual		Beverly Heathcare of 5. Social Security Number 6. Sec	redenck 7. Age (In yrs.	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birthp	lace (State or Foreign
	Funeral Director		a17 a6 8909 15	M 200 95	Yrs.	Months Days	Hours Min.	(Month, Da	19-10	Mary	$\overset{\scriptscriptstyle{n}}{\mathbf{I}}$ and
	р ,		Usual Residence of Decedent 10a. State 10b. County	100 0	ity, Town or Lo	neation.				1	0d. Inside City Limits
	anyle show	ž				ocation				'	1 ☐ Yes 2√E No
	the N	ect	MD Frederic	k Fre	derick	10f, Zip Code			10a Citize	n of What Cour	ntry?
	with	ī	30 North Place			21701			USA	TOT THIS COUR	y -
	death The 23	lera	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of H	ispanic Origin? (S	pecify Yes or No		Race - Americ	
21215-0036	s 1 end 2 should be filed within 72 hours efter death with the Marylend of Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other treumatic event, the Medical Exercine must be rotified at	by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	1	If Yes, specify Cuba 1 ☐ Yes 2X No	an, Mexican, Puert Specify:	o Rican, etc.)	sı	Black, White, becify: Whi	
20	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation		dent's Usual Occup		rkina	16b. Kind	of Business/Inc	
2	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "reumatic event, the Medicella Me	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	Au ig			
2	led w lygier her th		12	4	Medi	cal Techn	ician 18. Mother's Nan			h_Care_	
Maryland	ntal Had of	Be	17. Father's Name (First, Middle, Last) Harry Smith							intanie)	
Z	hould d Me mark matic	2	19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Maili	ng Address (Street	Pearl Ma			own. State. Zip	Code)
Z	end 2 s seith ar n 27 is ser treu		Clayton Smith/bro			Virginia					
Baitimore,	eges 1 end 2 ant of Heelth it: If item 27 it	-	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 ☑ Donation 5 □ Other (Specify)	20b. Removal from State	Place of Disp	osition (Name of matory or other place		Date		tion - City or To	
Baitir	permit, Peges ' Department of H importent: If ite any injury or ot once.		21. Signature of Funeral Service Licens Ronald S		or S	2. Name and Addre	tomy Boar	d 655 W	. Balt	timore !	Streat
	Physician /Medical Examiner	_	shoot or heart failure. List only of Immediate cause (Final disease or condition resulting in death) Sequentially list conditions,		ath. Do not en	Baltimore, ter the mode of dyin ルル	MD 2120	or respiratory a			Approximate Interval Between Onset and Death
8760,	tate be executed by sician and the burial-transit	dical Examiner	description of the control of the co	C							
.O. Box 6	The law requires that the death certific ate has been signed by the attending proage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	□Ectopic pregnancy	,		236	d. Date of delive Month	ery Day Year
Δ.	w requires that t been signed by should be deta	ed by Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	underlying cause giv	en in Part I.		obacco use Yes 250		he cause of death? pably 4 Unknown
Division of Vital Records,		Complet						24a. Was autor perfo		24b. Were auto prior to co death? 1 \(\text{Yes}	ppsy findings available mpletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	la a-ital.		Tou	THE R. WOLLS	ath (Check only o	one)		
5	Physic this c	ပို	TE 195 25 NO		ER/Outpatie		Nursing F	lome 5 Resident			y)
sion (E = = = = = = = = = = = = = = = = = = =	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	M 1	y at k? Yes 2 □ No	28d. Describe			
Divi	itel or At rs after d ei Direct led in by	Certif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, st	reet, factory, office	1	City or To		vumber or Hura	al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical		sician: To the best of my kr iner: On the basis of examin and manner stated.							
	To t withi To tl	M	29b. Signature and title of certifier	- HD		29c. Licens	e number 0 4799	51		signed (Month,	Day, Year)
			30. Name and address of person who co	1, Mb 814	TOU	L House	- Aue	FRE	DERI	C(C, 1	MD 2170
•	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 3 2006	32. Registrar's Sign	nature						
DH	MH 17 Rev 1/2	2001	MIN D LOVO							1	

		•	State of Ma		artment of Health a		iene _{eg. No.} 006	11575
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)	e J		2. Date of Deat Month	Day Year	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give street and number) Genesis Elder Care Long G		4b. City, Town, or Location of Baltimore		4c. County of Death	
	Funeral Director		5. Social Security Number 213-40-2024 Usual Residence of Decedent 7. Age 1 ☑ M 2 ☐ F	67 (In yrs. last birthday)	Months Days Hours	8. Date of Birth (Month, Day, Apr 18,	Year) Cou	place (State or Foreign ntry)
	Maryland -f ehow lind at	tor	10a. State 10b. County MD	10c. City, Town or Lo	ocation			10d. Inside City Limits 1
	th with the 23a or 28e ist be noti	al Director	10e. Street and Number 524 N. Charles St. #1500	Bartamore	10f. Zip Code 21201	11	0g. Citizen of What Cou	intry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "naturel", or Iteme 23a or 28e-f show other traumatic event, the Mudical Examiner must be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent I Armed Forces? 1 Yes 2 Never Married	10	Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☒ No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	ithin 72 hou na. "nature Madical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occupation b kind of work done during most DO NOT use retired)	of working	16b. Kind of Business/li	ndustry
	should be filed wand Mental Hygier marked other the	To Be Col	1.2 17. Father's Name (First, Middle, Last)	Copy V		r's Name (First, Middle, M	Baltimore (Maiden Sumame)	Sunpapers unk
, Maryland	1 and 2 shou Health and M Iem 27 Ie mar		19a. Informant's Name/Relationship (Type, Print) Genesis Elder Care-Long G	reen 115 1	ing Address (Street and Number E. Melrose Ave	nue Baltimoı	re, MD 2121	2
Baltimore,	permit. Pages 1 Department of He Important: If Iten any Injury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☒ Other (Specify) in state		matory or other place)		20c. Location - City or 1	own, State
Ba	Departing Control Cont		21. Signatur Funeral Prvice Licensee Hade Signature Funeral Signature 23a. Part 1. Enter the disease, or complications that caused	ector S	2. Name and Address of Facilit tate Anatomy Paltimore, MD 2 ter the mode of dying, such as	oard 655 W. 120		Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each lir Immediata Cause (Final disease or condition resulting in death) Due to (or as	oultolla a consequence of):	of Diabe	lie		Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A donsequence of):	or la la	S10-02		
8760,	death certificate be executed e ettending physicien end of for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as d.	aconsequence of:	orting of	liseofe		
.O. Box 6		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 monuts? 1 □ Yes 2 □ Mo 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
٥.	law requires thet the es been signed by th 2 should be detache	ρ	Part II. Other significant conditions contributing to death b	not resulting in the	Inderlying cause given in Part I		bacco use contribute to es 2 ☐ No 3 ☐ Pro	
I Records,	The law resete hes bee	Completed	Gloulouia Dirikan			24a. Was a autops perform	med? prior to death?	topsy lindings available completion of cause of
f Vital	ding Physician: The In. After this certificete he funeral director, page	To Be	25. Was case re erred to edical examiner? 1 Yes No Hospital: 1 Inpatie	ent 2 ☐ ER/Outpatie	Other	of Death (Check only or ursing Home 5 Reside		cify)
Division of	Attending Ph r death. ector: After th by the funeral	Certification;	27. Manne 1 Death 1 tural 5 Pending (Month, Da 2 Accident investigation 3 Suicide 6 Could not be	ıry 28b. Time o y Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □	No	ow injury occurred	
DIX	To the Hospitel or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Certific	4 Homicide determined 256. Place of in building, et	iury - At home, farm, st	1-	City or Town		
	the Hosi in 24 ho the Fund poletely f	ledical	29a. Certifier (Check only one) (Check one) (Check only one) (Check only one) (Check one)	examination and/or in	nvestigation, in my opinion, dea	ath occurred at the time, d	date and place, and due	to the cause(s)
	with To 1	≊	29b. Signature and title of certifier	1 MD	DH76H	H	APLU 6	1006
-			30. Name and address of person who completed cause of c	le Bol	Phinore 21	2/2	11	
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	Les of the second			

			For State Registrer	State of Marylan			of Health and of Death	Menta	al Hygien Reg. N	10 W	11576
	Physici	an	1. Decedent's Name (First, Middle, La	st)					ite of Death	ay Year	3. Time of Death
1	/Medic		Dorothy			بمطح		AA	it 0	8 2006	3:130 M
Ì	Examir	er	4a. Facility Name (If not institution, give	street and number)	f 4	4b. City, Tow	m, or Location of Dea	th	4	c. County of Dea	th
			The Johns Hople	ins Hospita	last hirth days	If Under 1 Y	ear If Under 24 Hrs	100	A st Dist	NA	100000000000000000000000000000000000000
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. I			ays Hours Min	. M	te of Birth onth, Day, Yea	r) C	thplace (State or Foreign
			Usual Residence of Decedent	85				mo	y 8,192	2	V 1/F .
	yland		10a. State 10b. County	10c. City	, Town or Loca	ation					10d. Inside City Limits
	e-f	Director	MD N/a	BAI	+max						12 Yes 2 □ No
	iff the	Sire	10e. Street and Number	4		10f. Zip Co	de		10g. C	itizen of What C	ountry?
	23a	<u>a</u>	1228 N. A139	with St		2/0				USA.	
36	72 hours after death with the Maryland natural', or iteme 23a or 28e-f ehow Jical Examinar must be rodilled at	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 A Modowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			of Hispanic Origin? (Cuban, Mexican, Puer Specify:	Specify Yo to Rican,	etc.)	14. Race - Ame Black, Whi	e, etc.
Ö	72 hours natural', ilcal Ext	bel	15. Decedent's Ed	lucation	16a. Deceder	nt's Usual O	ccupation		16b.	Kind of Business	
21215-0036	⊆ - ₽	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give kii life. DC	nd of work di DNOT use re	one during most of wo stired)	orking			,
5	d with giene.	E	Elementary (0 12)	0	Don	43/10	WORKER			DOMESTIC	
B	be filed htal Hygi ed other event, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First	Middle, Maide	en Sumame)	
<u>a</u>	Duid be Mental arked o	5	ROBERT ROBB				SAILE	- Ra	y		
Maryland	2 sh and Is m	1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing		reet and Number or R		.93.3	or Town, State,	Zip Code)
	s 1 and f Health item 27 other tr	,	DRENDE PRACTER	lee p	8711 HA		GINE #22 C		4	21045	<u> </u>
Baltimore,			20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Removal from State	lace of Disposit emetery, crema	tion (Name o itory or other	place)	Date		Location - City or	Town, Slate
Ë			4 □ Donation 5 □ Other (Specific	n) MAR	yland N	atrova	1 4-	150	6 8	aure/ M	D
3a	permit. Pa Departmen Important: any injury		21. Signature of Funeral Service Licer	\$88			ddress of Facility				
	40240		23a. Part1. Enter the disease, or com	plications that coursed the death			Areline St			21313	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a Due to (or as a const.)							Interval Between Onset and Death
V	ficete be executed physician and s the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequence)							
68760,	siciar b buri	le l		4							
89		edical		, d.						_	anga alaki da di
P.O. Box	he death certifi / the attending ched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ √√o 9 ☐ Unknown	23c. If yes, outcome of pregnated to the second of the se	death 3 E	ctopic pregn Other (specif				23d. Date of de Month	livery Day Year
	law requires that the de as been signed by the a 2 should be detached		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the und	erlying cause	given in Part I.	23	Be. Did tobacco	use contribute to	the cause of death?
ds	puires i signe	d by							1 Tes	2 12 No 3 □ P	robably 4 Unknown
Vital Records,	w requir s been si should	Completed		•				24	la. Was an	24b. Were a	utopsy lindings available completion of cause of
æ	0 2 0	E							autopsy performed?	death?	
ta	sician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of De		ØYes 2□N	10 TU Y85	2 D-No
\equiv		0 8	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 1	ER/Outpatient	3□ DOA	Other			6 ☐Other (Spe	cifv)
ا م	g Physical this seral di	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	T .	escribe how in		
Ö	ath.	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		i i i jui y		1 Yes 2 No				
Division	tal or Atters after de si Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stree /)	t, factory, of	rice		cation (Street a ty or Town, Sta		ural Route Number,
	To the Hospital or Attending PI within 24 hours after death. To the Funarai Director: After the completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my know niner: On the basis of examinat and manner stated.	wledge, death o tion and/or inves	occurred at the stigation, in r	ne time, date and plac my opinion, death occ	e, and du urred at ti	e to the cause(ne time, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier				ense number		29d. D	ate signed (Mon	h, Day, Year)
				MD		REC	5-000		AF	ril 8,2	006
	2		30. Name and address of person who	1		rint)					
	<i>a</i>			nd Itopkins Itospite		rth Wal	Getheat Be	Thus	amo	21287	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	lure	A.					

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For Amend Item#5 Registrar	pertain	685 377 57	6/08ee	rtment rtificate	t of H e <i>of L</i>	lealth a Death	and M		giene Reg. No		11577
		1. Decedent's Name (First, Middle,	Last)							2. Date of De		V	3. Time of Death
Physici /Medio		Theresa			St	topows	ski			April	1 1	. 2006	0018 M
Examir		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, 1	Town, or	Location of	of Death		40	. County of Deat	
			al Hospi				ast					Talbot	
Funeral Director		214-26-7552	6. Sex 1□ M 2□F	7. Age (In yrs. 76	last birthday) Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 23	th ly, Year 192	9. Birti Co 29 Mar	nplace (State or Foreign untry) y l and
*		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	eation							10d. Inside City Limits
if item 27 is marked other than "naturel", or iteme 23a or 28a-f show or other traumatic event, the Medical Exam per must be inclified at	5	,	+			oation							1 □XYes 2 □ No
28a-1	Director	Maryland Talbo	L		Easton	10f. Zip	Code				10a Ci	tizen of What Co	
io e	ā	39 Park Lane				216					rog. Ci	USA	unity
Ħ	era	11. Marital Status		edent Ever in U	S 13 1			isnanic Ori	gin? /Sne	cify Yes or No		14. Race - Ame	ncan Indian
	by Funeral	1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	orces? 2[X]No ve		fYes, spec 1 ☐ Yes 2	rfy Cuba	Specify:	i, Puerto P	Rican, etc.)		Black, White	
	Completed by	15. Decedent				dent's Usua			A = 4		16b. K	(ind of Business/l	ndustry
	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of wor DO NOT us	k done d e retired	during mos ()	t of workin	19			
	М	12			Homen	naker						House	ho1d
	Be (17. Father's Name (First, Middle, L	ast)							(First, Middle	, Maider	-	
	2	Joseph		Plotc	zyk			Co	nstar	ice		R	osinski
ADGE.		19a. Informant's Name/Relationsh Joseph Stopowsk	ip <i>(Type, Print)</i> 1 SP(ouse						Route Number 1 MD 21		or To wn, State. Z	ip Code)
5		20a. Method of Disposition			Place of Dispo	sition (Nam	e of	A)	Di	ate	20c. L	ocation - City or	Fown, State
		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (Sp			tro Cre				/14/2	2006	Balt	timore M	arvland
SUCE.		21. Signature of Funeral Service	/ V/			Name and			Jua	llings	Fur	neral Ho MD 21122	
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that on	aused the deat								10 2 1 1 2 2	Approximate Interval Between
ın		Immediate Cause (Final disease or condition	À	A. D. J.		NUW							Onset and Death
al		resulting in death)	a. Due to	(pr as a conseq	-	MAL	101	100					
er			COVI	$\alpha \alpha \alpha \alpha$	recou	die	Pisc	0					
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	uence of):								
	Examiner	that initiated events	o. Chc	DONL P	empley	cem	^						
	EX	resulting in death) Last	Due to	(or as a conseq	uence of)		4		-				
	dical	23	La De	menti	a								
	Med	IF FEMALE:											
	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live b	tcome of pregna birth 2 Feta nant at time of d own	l death 3□	Ectopic pre Other (spe						23d. Date of deli- Month	very Day Year
מפושכו וכי חפושכו פס מפושכו וכי מפישכו	Y P	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the u	nderlying ca	use give	en in Part I.		23e. Did t	obacco	use contribute to	the cause of death?
2	Q p									10	Yes 2	□No 3□Pro	bably 4 @Onknown
	Completed by	•								24a. Was	20	24h Ware 200	opsy findings available
	E I									autop		prior to c	ompletion of cause of
medial page 2		OS Man and advantage and death								1 Yes	-		2 No
3	Be	25. Was case referred to medical examiner?	Hospital:				A Othe			Check only c			
3	. To	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatien 28b. Time of					le 5 ☐ Resid 8d. Describe I		6 ☐Other (Spec	ıfy)
TUDE	Certification:	1 ☑Natural 5 ☐ Pending	(Mon	th, Day Year)	Injury	M	Bc. Injury Work	(? /es 2 □ I		od. Describe	now inju	ny occurred	
/ the	Ica	3 ☐ Suicide 6 ☐ Could no	1 ha	of laius. At h	omo farm etr					94 Location /	Stroot 2	nd Number of Du	ral Route Number.
5	i i	4 Homicide determin	ned 200. Place buildi	of Injury · At heng, etc. (Specif	y)	eet, ractory,	OHICO		1	City or Tox			rai Houte Number,
		29a. Certifier 1FT Certifying	Objective To the	hart of our loss									
compretery trited in by the funeral director.	Medical	(Check only 2 Medical E	Physicien: To the xeminer: On the b and man	asis of examina ner stated.	ition and/or inv	estigation,	in my op	pinion, dea	d place, al	d at the time,	date an) and manner as d place, and due	stated. to the cause(s)
CO	≥	29b. Signature and title of certifier	/			29c.	License	number			29d. Da	te signed (Month	, Day, Year)
		Houds -	ranet	m)	D	105	147	62		41	1406	
n		30. Name and address of person w	no completed caus	se of death (Iten	n 23a) (Type,	Print)		asto			- /	, , ,	
Ψ	1	Haider So	M, torr	D			F	asta	N, N	C/N			
Sta	te	31. Date filed (Month, Day, Year)	22. F	legistrar's Signa	iture	- department				-			
gistr	ar	APR 1 3 20	06	in B.	A 234	1							

			For State Registrar	State of Marylar		artment of F			iene () ()	11578
			Decedent's Name (First, Middle, La	ist)				2. Date of Deat	h _	3. Time of Death
	Physici /Medic		Robert	Wilmer	S	eward	Jr.	April	8 2006	6:30A M
	Examin		4a. Facility Name (If not institution, gr				or Location of Deat	h	4c. County of	
	4 4		8393 Lockwood I			Pasade If Under 1 Year				Arundel
	Funeral Director	S	0.4 = 4.4 33300	Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F 83	Yrs.	Months Days		8. Date of Birth (Month, Day, March 3	0,1923	Mary land
	pug *		Usual Residence of Decedent 10a, State 10b, County	10c Ci	ty, Town or Lo	cation			/	10d. Inside City Limits
	f eho	ō	Maryland Anne A	1	sadena					1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23s or 28s-f show r mast be notified at	Director	10e. Street and Number 8393 LOCKWOOD RO	nad		10f. Zip Code	122	1	0g. Citizen of Wh	at Country?
	eath v	Funeral	11. Marital Status	12. Was Decedent Ever in U	S 113.1		Hispanic Origin? (S	nacify Vas or No-		American Indian,
0000	be filed within 72 hours after death with the Marylar ital Hyglene. Id other then "natural", or items 23a or 28a-f show event, the Micilcal Examination in all be notified at	by	1 Never Married 2 Marned 3 Widowed 4 Divorced	Armed Forces?		f Yes, specify Cub	an, Mexican, Puerl	o Rican, etc.)	Black,	white, etc.
5	72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation	16a. Dece	dent's Usual Occup	pation	rking	16b. Kind of Busi	ness/Industry
V	Aithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of world)	Ning.		
V	filed v Hygie ther t		11 th 17. Father's Name (First, Middle, Las	()	Ship	Fitter	18. Mother's Nar	ne (First, Middle, M		t Guard Yard
Jana	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mi	To Be	Robert W	Seward S	Sr.		Alice	(, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	unkno	wn
Mar	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship Glen A. Seward	(Type, Print) SON				oral Route Number, Pasadena		
n,	item other		20a. Method of Disposition	,		sition (Name of matory or other pla	ca)	Date	20c. Location - Ci	ty or Town, State
Ē	Pages nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec	Removal from State		11 Cemete	· 1	/2006	Glen Bur	^nie MD
Dallimor	permit. Pages 1 and 2 Department of Health s Important: If item 27 is eny injury or other tra 9002:		21. Signature of Funeral Service Lide	niee		2. Name and Address	31	tallings i Pasaden		Hore P.A.
			23a. Part1. Enter the dise se, or con shock, or heart failure. List only	nplications that gaused the dear						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Thronic	obit	suctine	Pulmone	my Du	teinto	Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a consec	quence on:	- W COOL	V CHIO - IN	0		
	· 第 第二	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):					
	cuted nd ransit	Examine	that initiated events	C						2
Ď,	sate be executed physicien and the buriel-transit	I Ex	resulting in death) Last	Due to (or as a consec	quence of):					
00/00	physic physic the b	dicai	•	d					·	
X	certifi Iding	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date	of delivery
	0 0 0	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		Ectopic pregnanc Other (specify) _	у		Month	,
	that the	y Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	pacco use contrib	ute to the cause of death?
Spios	w requires that the de been signed by the a should be detached	ed by						1 □ Y€	as 2□No 3	☐ Probebly 4 Nhknown
ָ ב	2 2 2	Completed						24a. Was a autops perform 1 \(\text{Yes} \) 2	y prio	re autopsy findings available or to completion of cause of ath? Yes 2 500
12	sician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only on	7-	
5	Physician: this certific ral director,	-T	1 ☐ Yes 2 No 27. Manner of Death		ER/Outpatier	I JU DOA		lome 5 Reside		
SION	ding th. : After funer	tion	1 Natural 5 Pending 2 Accident investigate	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryat rk?]Yes 2∐No	280. Describe no	w injury occurred	
<u> </u>	r Atter ter dea rector by the	ertification:	3 ☐ Suicide 6 ☐ Could not determine		ome, farm, str fy)	eet, factory, office		28f. Location (St. City or Town	reet and Number	or Rural Route Number,
ב	pital o	O	200 0-16-							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	edical	29a. Certifier 1 XOCertifying P (Check only one) 2 Medical Exa	hysician: To the best of my knominer: On the basis of examination and manner stated.	ation and/or in	vestigation, in my	me, date and place opinion, death occu	e, and due to the ca	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licen:	se number	25	9d. Date signed (Month, Day, Year)
	161			/		458	458	- 4	+/10/1	76
	らす!		30. Name and address of person with	completed cause of death (Iter	п 23a) (Туре,	Print) Han	1	w ales	h Pinn	nie MD2106/
	Sta	te	31. Date flied (Month, Day, Year)	35 Registrar's Sign	ature	all 1	many "	w me	ハンリナ	IK MUDALUL
	Registr		APR 1 3 20	106 litera de	1998		V			

Lee Artis Tatum 06-02048 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylar	•	irtment of F tificate of		d Mental Hyç	giene	06	1 5	79
	Diversitati		Decedent's Name (First, Middle, L.	ast)	_				2. Date of Dea	ıth	Vear	3. Time of	Death
	Physici /Medic		Lee Ar	tis Tatı	ım				March	23	2006	5:45	Ам
	Examin	er	4a. Facility Name (If not institution, gi		ber)		4b. City, Town, o	or Location of D	eath	4c. Cou	inty of Death		
			Johns Hopkins Hos 5. Social Security Number 6.		Ann (In vrs	last birthday)	Balti If Under 1 Year		Hrs. 8. Date of Birt		N/A	place (State o	or Foreign
	Funeral Director	1	430-64-3473	1 2 M 2□F	68	Yrs.	Months Days		Min. (Month, Da)	7 3 8	Cou	AR	or r oreign
	P .		Usual Residence of Decedent										
	anylar	ž	10a. State 10b. County	I/A	10c. Ci	ty, Town or Lo	Baltin	ore Ci	i t v			10d. Inside C	ity Limits 2 ☐ No
	the M	ecto	10e. Street and Number				10f. Zip Code	.010 01		10a Citizon	of What Cou		20110
	hours after deeth with the Maryland tural; or Items 23a or 28a-f show al Examination multiplied at	Funeral Director	401 East 25t	h Stree	t Apt	311c	21218	3		rog. Citizen	USA	,	
	deeth	nera	11. Marital Status	12. Was Deced			Vas Decedent of I	Hispanic Origin	(Specify Yes or No-		Race - Ameri		
9	after or Ite	/Fu	1 Never Married 2 Married	Armed Ford 1 Types 2 If Yes, Give		IIK.	Yes, specify Cub		ueno nican, etc.)		Black, White, ac <i>ify:</i> B	etc. 1ack	
21215-0036	hours urs!',	d by	3 Widowed 4 Divorced	Year or Dat	tes:								
,	filed within 72 Hygiene. other than "nal ent, the Wadio	Completed	15. Decedent's E (Specify only highest g	rade completed)		(Give	lent's Usual Occup kind of work done OO NOT use retire	during most of	working	160, Kind o	f Business/Ir	idustry	
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4	40r 5+)		Labore	er		Odd	Jobs		
2	al Hygi al Other vent, I	Bec	17. Father's Name (First, Middle, Las	•					Name (First, Middle,		name)		
<u>X</u>	should be filed within 72 hours after deeth with the Marylar and Merital Hygiene. a marked at Hygiene. a marked other than "natural", or items 23a or 28a-f show that the Wadical Examinating must be notified a cumatic avent, the Wadical Examinating must be notified.	L	Sherman Tat						dys Popla				
Maryland	2 2 3 3	1	19a. Informant's Name/Relationship Ernastine Be		Sist				r Rural Roule Numbe St., Milv			5321	0
	1 and 2 Health tem 27		20a. Method of Disposition	aruen /	20b. F	Place of Dispos	sition (Name of	1	Date		on - City or T		
altimore,	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		tate	cemetery, cren . Zion	natory or other pla Cem A	1	2, 2006	Fait			
Ħ	교문원들 .	1	21. Signature of Fur eral Service Lice		110		. Name and Addre	ss of Facility			II AIX		
Ö	Depermination of the series of		1240						s Funeral Ho e. Baltimore		30		
			23a. Part1. Enter the disease, or con shock, or heart failure. List ont	nplications that ca y one cause on ea	used the deat ch line.	th. Do not ente	er the mode of dyi	ng, such as care	diac or respiratory ar	est,		Approximat Interval Bet	ween
	Physician	8	Immediate Cause (Final disease or condition	a. 5to	1000	und o	f Alsdor	nen a	ity Con	plea	tions	Onset and	Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consec	quence of):				ð. S			
	4	e	Sequentially list conditions, it any, leading to immediate	b. Oue to (a	r as a consec	uanta of):							
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events										
o`	be executed sicien and burial-transit	Exa	resulting in death) Last	Due to (o	r as a consec	quence of):							
8760,	icate be executed physicien and the burial-transit	dicai		d									
9		Med	IF FEMALE:	00- 11						T	J.		
Box	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ome of pregna th 2 □ Feta nt at time of c	al déath 3 🗆	Ectopic pregnanc Other (specify)	у		23d.	Date of deliv Month		Year
o	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov		10au 5_	Other (specify)_						
1	The law requires thet the one best been signed by the sege 2 should be detached.	by Pt	Part II. Other significant conditions	contributing to dea	ith but not res	sulting in the un	derlying cause giv	ven in Part I.	23e. Did to	bacco use c	ontribute to t	he cause of c	death?
Division of Vital Records,	w require been sig should bi								_ 1 U Y	es 20 No	3 ☐ Prot	oabły 4 □l	Unknown
ပ္သ	law re Bs be 2 shc	Completed							24a. Was a		b. Were auto	psy findings impletion of c	available
ř		Com							perfor	med? 2 No	death?		au 30 01
/ita	yalclan: Th is certificete director, peg	Be	25. Was case referred to medical examiner?	Hospital: X					Death (Check only or	10)			
o	Phya this ral dir	: To	4Y☐ Yes 2☐ No 27. Manner of Death	28a. Date of		ER/Outpatient	3 DOA 28c. Injui		g Home 5 Resid			(y)	
5	el or Attending P s after death. Il Director: After ti ed in by the funera	tion	1 Natural 5 Pending 2 Accident investigate	(Month	Day Year)	Forma	Wo	rk? Yes 2 No		. ,	Stali	hod	
N S	Atter	Ifica	3 Suicide 6 Could not determined	28e. Place o	of Injury - At h	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Nu	mber or Rura	Al Route Num	iber,
	tel or rs afte al Dir ed in	Certification:	Anomicide	Dulidari	Anaut		buildin	Q	Buet	Lever	e of o	X5+115	· ·
	To the Hospitel or Attending Physician: which 24 hours after deals as a feet deals To the Funeral Director: After this certifice completely filled in by the funeral director; to	edical	(Check only 2 X Medical Exa	miner: On the bas	is of examina	owledge, death	occurred at the ti	me, date and pl	ace, and due to the c ccurred at the time, o	ause(s) and	manner ac c	tated.	s)
	thin 2 the 1 mplet	Med	one) 29b. Signature and title of certifier	and manne	or stated.		29c. Licens				ned (Month,		
	8 18 1		. 0	allan				O.C.M.E			24, 20		
1	1		30. Name and address of person who			m 23a) (Type 1					, 20		
0			Carolt. Allo	und		111	Penn Str	eet, Ba	ltimore, 1	Maryla	nd 212	201	
	Sta	te	31. Date filed (Month, Day, Year)	006 32 Re	gistrar's Sign	ture Con	de	•		-			

		,	For State Registrar	State of Maryland / D	epartment of Health and Certificate of Death	Mental Hy	-	11580
4	Dhusisi		1. Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death
	Physici /Medic		Erlene Juliette			April	12, 2006	8:44 A
	Examin	er	4a. Facility Name (If not institution, give st 1412 North Main Sti		4b. City, Town, or Location of De	ath	4c. County of Death	
	K. (4)	- 200	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Hampstead If Under 1 Year If Under 24 H	rs. 8 Date of Birth	Carrol	Anlace (State or Foreign
*	Funeral Director			M 0773 C	rs. Months Days Hours Mi	May 22	y Year) 9. Birth Court	th Carolina
	oeam with the Maryland me 23a or 28e-1 show r mart be notified at		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
1	89-f	Director	Maryland Carroll	Ham	pstead			1 ☐ Yes 2X No
1	B Or 2	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cou	intry?
	eam	erai	1412 North Main St	PECE 2. Was Decedent Ever in U.S.	21074	(Specify Yes or No-	USA 14. Race - Amer	ican Indian
		Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes No If Yes, Give	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put1 ☐ Yes 2 ☒ No Specify:	erto Rican, etc.)		, etc.
200	nours arrer tural', or Ite	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:			Specify: Wr	nite
0	within 72 rene. than "nati	lete	15. Decedent's Education (Specify only highest grade	completed)	Decedent's Usual Occupation 'Give kind of work done during most of и life. DO NOT use retired)	rorking	16b. Kind of Business/I	ndustry
7 .	t the second	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Caregiver		Self Emp	loved
and	tal Hyg	Bec	17. Father's Name (First, Middle, Last)			ame (First, Middle,		, Loy Cd
À d	Ment Ment arked arked	To	Raymond H. Thomas		R	uby Flowe	ers	
Mar	d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship (Typ		Mailing Address (Street and Number or			
້ .	Heal Heal Bm 2		Keith B. Sock, So 20a. Method of Disposition	20b. Place of	12 North Main Stre	et Hampst	ead, MD 210	
	9 5 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State cemetery	crematory or other place)	/13/06	Baltimore,	
Daitimor	permit. Page Department of Importent: If any Injury or ance.		21. Signature of Funeral Service Licenses Thomas Gregor		22. Name and Address of Facility Cremation Society 299 Frederick Roa			
/ hoo,	The private and the private an	lical Examiner	23a. Part1. Enter the disease, or complic stock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequence of	Lypertension Stenosis	iac or respiratory ar		Approximate Interval Between Onset and Death a week Several Several Several Years
ָ כ	w requires mai me death certificate be ex been signed by the ettending physicien should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 12 No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deline Month	very Day Year
, ,	requires that een signed b hould be deta	by P	Part II. Dither significant conditions cont	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ecords	equire sen siç ould t	ted	Diabetes M	elitus		1 🗆 Y	∕es 21⊈No 3 ☐ Pro	bably 4 Unknow
J Hec	Inelay ate has page 2	Completed				24a. Was autop perfo	rmed? prior to c death?	topsy findings available ompletion of cause of
Vital	Pnysicien: this certific ral director,	Be	25. Was case referred to medical examiner?	anital:		eath (Check only o	ne)	
5	this	: To	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. Ti			dence 6 Other (Spec	ufy)
ם י	Attending is a death. actor: After by the funer	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year) In	jury Work? M 1 □ Yes 2 □ No	20d. Describe i	iow injury occurred	
=	p ag ig ⊡	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (S City or Tow	Street and Number or Ru vn, State)	ral Route Number,
	To the Mospitel within 24 hours and the Funerel I completely filled	Medical C	29a. Certifier 12 Certifying Physic (Check only one) 2 Madical Examin	cian: To the best of my knowledge, ar: On the basis of examination and and manner stated.	death occurred at the time, date and pla for investigation, in my opinion, death oc	ice, and due to the courred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
;	vithii To the	×	29b. Signature and title of certifier	la	29c. License number D 36// 7		29d. Date signed (Month) 4-12- 20	
	la	ļ	30. Name and address of person who cor		Type, Print)			
	U		D. Alexander Rocha	, M.D. 4231 Nort	hwoods Trail Hamps	tead, MD	21074	
130	Sta	te	31. Date filed (Month, Day, Year)	32. egistrar's Signature	-			

DHMH 17 Rev 1/2001

Registrar

Amend Item 1 per M.d & Item 22 per F.H G-854 4/13/06 reb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of Marylan			h and Me	ental Hyg	•	58 anno
	Physici		1. Decedent's Name (First, Middle, Last	Joseph A	lfred Tur	ner, Jr.	4	2. Date of Deat Month	Day Year	
	/Medio Examin		4a. Facility Name (If not institution, give University of the 5. Social Security Number 6. Se	laryland H	redice (der 1 Year If Un	trmore	3. Date of Birth	4c. County of Dea	Ath Anthplace (State or Foreign
*	Director		Usual Residence of Decedent	M 2□F 62	•	ns Days Hou	irs Min.	(Month, Day, VDV 16	1943	ountry) W V
	vith the Marylar t or 28e-f show	Director	10a. State 10b. County CARRO 10e. Street and Number	OLL EL		Zip Code		1:	0g. Citizen of What C	10d. Inside City Limits 1 X Yes 2 □ No ountry?
920	within 72 hours after death with the Maryland ans. than "natural", or items 23a or 28e-f show he Medical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Byes 2 □ No 196 If Yes, Give Year or Dates: 199	.S. 13. Was De	2/-7-2 procedent of Hispanic specify Cuban, Mex s 2 No Spec	Origin? (Spec kican, Puerto R	fly Yes or No- ican, etc.)	14. Race - Am Black, Wh	ite, etc.
121215-0036	2 should be filed within 72 ho and Mental Hygiene. is marked other than "natur eumatic event, the Modice!	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)		16a. Decedent's U (Give kind of life. DO NO SUPPLY	work done during r Tuse retired) SPECI	ALIST	,	16b. Kind of Business NATIONAL AGE Maiden Sumame)	- SECURITY
Maryland	ould be fi Mental H harked of	To Be	JOSEPH A TURN	······································			ROSE	YOUN	G	
	ges 1 and 2 should to f Health and Men if item 27 is marke or other treumatic		19a. Informant's Name/Relationship (T)	N/WIFE_	6804 A	lutuma	View	Drive		NGMO 21784
Baltimore	Pages 1 ment of H ant: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		Place of Disposition (cometery, crematory) KE VICW	mem PK	4/11/	2006	20c. Location - City o	e mo
Ball	Department important: important: any injury o		21. Signature of Funeral Service Licens	embuen	602°	SYKCSU	ALLEXX	Zuma.	NUV FH & / Eldersburg	nov Co , Md. 21784
	Physician /Medical Examiner		23a. Påfi1. Šhter the disease, or cómp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	Liver dence of):			respiratory arre	est,	Approximate Interval Between Onset and Death
60,	be executed ician and burial-transit	Jicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence)	uence of):					unknowh
P.O. Box 68	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	il death 3 □Ectopi	c pregnancy (specify)			23d. Date of do Month	elivery Day Year
rds, P	quires that n signed b	þ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying	ig cause given in P	art I.	23e. Did tot	- /	to the cause of death? Probably 4 □Unknown
al Records,		Completed						24a. Was a autops perform	v prior to	
Vital	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital: L		Othor	lace of Death		Ü.	5/376
of	Attending Physician: r death. sctor: After this certification the funeral director.	ion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28		ence 6 Other (Sp ow injury occurred	ecify)
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funers! Director: After this certific completely filled in by the funeral director.	Medical Certification:	2 Ccident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac			Bf. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
io Sy	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) 2 Medical Exam	sician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occur ation and/or investigat	red at the time, date tion, in my opinion,	e and place, ar death occurred	nd due to the ca	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
10	To ti withi To ti comp	Σ	29b. Signature and title of certifier	Cellan		29c. License numb			9d. Date signed (Mor	-
			30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type, Print)				April 4	'
	Sta Regist		Angela Wal 31. Date filed (Month, Day, Year) APR 1 3 2006	32. Registrar's Signa					, ,	1

				1 - For State Registrar	State of Ma		epartmer <i>Certifica</i> :				giene 🗍 (Reg. No.	96	11582
		Physic		1. Decedent's Name (First, Middle, La				-		2. Date of Dea Month	ath Day	Year	3. Time of Death
	H	/Medi Exami		Marshall S. Turne 4a. Facility Name (If not institution, give					Location of Death			y of Death	5:05A
		Funeral Director		220-30-2883	Sex 7. Ag	e (In yrs. last birt		imoni r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Feb. 1	h v. Year)	Coun	lace (State or Foreign
		death with the Maryland ms 23a or 28e-f ehow Emust be notified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo	ore	10c. City, Town	monium						0d. Inside City Limits 1 ☐ Yes 2 ☑ No
		th with the 23a or 2	ai Dire	10e. Street and Number 2525 Pot Spring I	Road, #L325	5		1093			10g. Citizen of United		•
	920	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28e-f show other treumatic event, the Medical Examiner must be notified as	by Funeral Director	11. Marital Status 1 Never Married 212 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 XI If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 \(\subseteq Yes		spanic Origin? (Sp , Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ce - Americ ick, White,	an Indian,
	21215-0036	within 72 hc ene. then "natur he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5		Decedent's Usu (Give kind of wo life. DO NOT u	ork done di	tion uring most of work	sing	16b. Kind of B	Hopk	
	1d 21	e filed withing Hygiene. other then	Be Cor	17. Father's Name (First, Middle, Last	5±	D	irector		thletics 18. Mother's Nam		Unive		
A.M.	Maryland	should be nd Mental marked o	ToE	Marshall S. Turne 19a. Informant's Name/Relationship (19b.	Mailing Address	s (Street a	Louis		r, City or Town	, State, Zip	Code)
5:05	altimore, Ma	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then any Injury or other treumatic event, the Ma ODGs.		Mrs. Lois G. Turr 20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Nother (Specia	Removal from State	20b. Place of cemeters	Disposition (Na y, crematory or	me of other place)	#L325, 7	20c. Location	- City or To	wn, State
	Baltir	permit. F Departme Importan eny Injur		21. Signature of Fune II S		M01113	22. Name a	nd Address	Gins. 4/1 s of Facility Br 7, P.A. 200	rian T. Ch		uneral	Services of
		Physician /Medical Examiner		23a. Par1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a End	a consequence of	290		kinsm'		rest, EOSC		Approximate Interval Between Onset and Death MONTAS
			Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence o	of):						
9	8760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as	a consequence o	of):						
12, 200	O. Box 6	n certifi anding I use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s _k					ate of delive	ry Day Year
APRIL	ecords, P.	requires thet the death een signed by the ette nould be detached for	ed by Pt	Part II. Other significant conditions (contributing to death b	ut not resulting in	the underlying o	cause give	n in Part I.		es 2 🖾 No		e cause of death?
,	0	The law ate has b page 2 sl	Completed by							24a. Was autop	med?	Were autoportor to condeath?	osy findings available apletion of cause of 2 No
TURNER	Vital		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 255.No	Hospital: 1 ☐ Inpatie	int 2□ER/Out	patient 3 D0	Other	26. Place of Deat	h <i>Ch</i> eck only o		her /Specific	1
MARSHALL	Division of	g Ph er th	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Inju (Month, Date	ry 28b. T Y Year) In	ime of ijury M	28c. Injury Work' 1 🗆 Y		28d. Describe h	ow injury occur	rred	
MARS	Divi	s after d al Direct ed in by	Certifi	4 Homicide determined	28e. Place of Injubulding, etc.	ury - At home, far c. (Specify)	m, street, factor	y, office		28f. Location (S City or Tow	itreet and Numi m, State)	ber or Aurai	Route Number,
5	Ĭ	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: All completely filled in by the fur	Medical (29a. Certifier 1	nysician: To the best of miner: On the basis of and manner sta	examination and	, death occurred Vor investigation	at the time	e, date and place, inion, death occur	and due to the cred at the time, c	ause(s) and m date and place,	anner as sta	ated. the cause(s)
		T SOUTH THE	Σ	29b. Signature and title of certifier Emestin	e War	ight, v	M) 29	c. License	2740)	April	12 th	2006
11		(0)		30. Name and address of person who ERNESTINE WRIGHT		eath (Item 23a) (* .	LEY R	OAD TIM	ONIUM, I	MD 2109	3	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 3 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

							Cer	tificate of	Death		Reg. No.	Jb	11583
	Physicia		1. Decedent's Nam				-			2. Dete of De Month	eeth Day	Year	3. Time of Death
	/Medica	ıl -		LLIE TUC						APRIL	4, 2006		11:10 PM
	Examine	r	-	-	ve street and number	r)				r Location of Dee			
			Sacred					K I In dead Mana		ville, M			
	Funeral Director		5. Social Security N 578-22-3	722	Sex 7. A 1 □ M 2 ¼ F	93	ast birthday) Yrs.	Months Days	If Under 24 Hr Hours Min	8. Date of Bi (Month, D MAR . 8,	irth <i>ay, Yeer)</i> 1913	Countr	ace (State or Foreign y) Cy, N.C.
	pue 🔏	\perp	Usuel Residence of 10a. State	Decedent 10b. County		10c City	, Town or Lo	cation				10	d. Inside City Limits
	Aenyt	5	DC	, out out,		-						10	14 Yes 2 No
	the 158	နို	10e. Street and Nur	mber		77 6	asiiriig	ton, DC			10g. Citizen of	What Countr	2
	23a or	Funeral Director	702 Colum		, N.W.			200	01		USA	Wilat Count	y r
	de d	ner.	11. Marital Status		12. Was Deceden	t Ever in U.S	S. 13. V	Vas Decedent of F	Hispenic Origin?	(Specify Yes or Norto Rican, etc.)	o- 14. Rac	ce - America	
0200-612	init. Peges 1 and 2 should be filed within 72 hours effer deeth with the Meryland setment of Health and Mentel Hygiene. ortant: if item 27 is merked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Exercities must be notified at an analysis of the following the contraction of the following the contraction of the following the follow	D L	1 ☑ Never Marri 3 ☐ Widowed	ied 2 Married 4 Divorced	1 ☐ Yes 2 K If Yes, Give Year or Dates	No No		☐ Yes 2 No		ento Filican, etc.)	Specif	ck, White, et $y: B1a$	
ה ה	natur	S S	(Spec	15. Decedent's E	ducation		16a. Deced	ent's Usual Occup	petion	orkina	16b. Kind of B	usiness/Indu	ıstry
7	within	Completed by	Elementery/Seco		College (1-4or	5+)	life. E	kind of work done OO NOT use retire Cook	d)	Orking	Priv	ate Ir	ndustry
7	Hygie Ther int, is		12th 17. Father's Neme	(First Middle Last	•)				18 Mother's No	ame (First, Middle			
yiand	d be sented of the control of the co	0 26		Wesley Tu	•					Belle Gyr		110)	
2	shou nd Mi mari	-	19a. Informent's Na				19b. Mailin	a Address (Street		Rurel Route Numb		State Zio C	Code)
Z Z	ofth e	-	Barbar	ra Gillus	Niece		1			V, Washi			
<u> </u>	of Her		20a. Method of Disp			20b. Pl		sition (Neme of natory or other pla		Date	20c. Location		
anumore	permit. Peges Depertment of Important: if it any injury or once.			∠Cremation 3 L 5 ☐ Other (Special Control of the control of t	Removal from State (fy)					4/11/06	Riverda	le, MI)
	Depertr Depertr Mports Any inju		21. Signature of Fu	neral Service Lice	nsee 2		22.	Name and Addre	ess of Fecility I	razier's	s Funera	1 Home	e, Inc.
	80 = 2 8		160	Shan.	- 11/2	11/2	- 38	9 Rhode	Island A	lvenue, l	WW, Wash	.,DC 2	20001
		7	23a. Pert1. Enter the shock, or hear	ne disease, or com nt failure. List only	plications that cause one cause on each	ed the death.	. Do not ente	r the mode of dyir	ng, such as cardia	ac or respiratory a	arrest,		Approximate nterval Between
F	hysician												Onset and Death
	/Medical Examiner		Immediate Cause (disease or condition resulting in death)		a ARTERIC	SCLER	OSIS						
		- d	rooming in douin,				as a consequ	uence of):				1	
1	ansit			•	b. ARRYTHM			-				1	
5	physicien and strensit the burial-transit	Z	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nditions, mediate riving	MULTI C		as e consequ FATT.IIR					1	
00/00	ysici	2	Cause (Disease or that initiated events resulting in death) L		c		as a consequ					1	
١	ding ph		resulting in death) L	asi								İ	
	ttendi or us	9			d							1	
5	d by the ettence detections of the ettence detections.	300	Part II. Other signifi	cant conditions	ontributing to death I	out not resul	lting in the un	derlying cause giv	en in Part I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
	ed by detect				OSTEOPERO	SIS				10	Yes 2□ No	3 Proba	bly 4 💢 Unknown
ה ה	signer in signer	2								24a Was	an autopsy	24h Were	autopsy findings
5	beer shou	1									omed?	avail	able prior to pletion of cause
ב ב	tate hes been si pege 2 should									10	Vac of Na	of de	
ָ נַם	entificat setor, p		25. Was cese referr	ed to medical					26 Piece of Do	aath (Check only	<u> </u>	10,	Yes 2□ No
> :	als cert		examiner? 1 ☐ Yes 2 🔯	No	Hospital:	ient 2 E	R/Outpatient	3□ DOA Oth		Home 5□Resi		er (Specify)	
2	terth nerel		27. Manner of Death	o 5 ☐ Pending	28e. Dete of Inji (Month, De	ury ev Year)	28b. Time of Injury	28c. Injur Wor			how injury occur		
	or: Af		2 ☐ Accident	investigation	n		,,		Yes 2 □ No				
	rs after death. al Director: After tied in by the funer		3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	286. Place of In	jury - At hor tc. <i>(Specify)</i>	ne, farm, stre	et, factory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural F	Route Number,
3	De Sino		29a. Certifier	4 7			15.74.75						
1	within a Abours after death. within 24 hours after death. To the Funeral Director. After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the bunial-trensit. Medical Certification: To Be Completed by Dhysoldian Medical Examination.	200		2 Medical Exam	ysician: To the best niner: On the besis o and manner s	of examination	on and/or inve	estigation, in my o	ne, date and plac Pinion, death occ	e, and due to the urred at the time,	date and place,	inner as stat and due to th	ed. 1e cause(s)
	To the comp	-	29b. Signature and		P. T.	0.		29c. Licens	e number		29d. Date signe		ıy, Yeer)
	*		Ken	nau,		CI.		1019	609		4.5.0	6	
	The same of the sa				completed cause of								
					oad, Suit	e 202	- Gaji	thersbur	g, MD 2	0878			
	State Registrar		31. Date filed (Monti	PR 1 3 2	006	ar s Signay	to figure						

2				State of Maryland / Dopper State of Maryland / D				C C C C C C C C C C C C C C C C C C C
			1. Decedent's Name (First, Middle, Last)			2. Date Mon	of Death th Day Yea	3. Time of Death
	Physicia		Caryn M. Tapper				uary 19, 200	NA NA
	/Medic		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or	Location of Death	4c. County of D	eath
	LAdilliii	-	Carroll Hospital	Center	Westminst	or	Carrol1	
	Funeral		5. Social Security Number , 6. Sex	7. Age (In yrs. last birth		If Under 24 Hrs 0 Date	of Birth 9.1	Birthplace (State or Foreign Country)
	Director		unk ₁□	M 2√F 50	rs. Moritis Days	Apr	3, 1955	unk
7	,		Usual Residence of Decedent					10d. Inside City Limits
D-COOST	how		10a. State 10b. County	10c. City, Town	or Location			1 ☐ Yes 2x No
N.	4	5	MD Carroll	Westmin	nster			
4	28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What	Country?
1	338	aiD	88 W. Main Street		21157		USA	
000		Funeral	11. Marital Status unk	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, e		merican Indian, hite, etc.
3	9 8		1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes 2 ☑ No	Specify:	Specify:	
3	, a	by	3 Widowed 4 Divorced	Year or Dates:	10 103 200 100	opoony.		nite
	e in	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a. [Decedent's Usual Occupa	ution Juring most of working un	16b. Kind of Busine	· .
21212-0000		pje	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired,) un	ık	unk
	Hygiene. Sther ther ent. the M	DO.	unk u	nk				
2		Be	17. Father's Name (First, Middle, Last)		unk	18. Mother's Name (First,	Middle, Maiden Sumame)	unk
Mai yiaila	Mental Mental arked c	ToE						
	DE E		19a. Informant's Name/Relationship (Ty	pe, Print) 19b.	Mailing Address (Street a	and Number or Rural Route	Number, City or Town, Stat	e, Zip Code)
	2 4 2 2		O.C.M.E.	113	l Penn Stree	t Baltimore,	MD 21201	
ָטַ .	othe	l i	20a. Method of Disposition	cometan	Disposition (Name of v, crematory or other place	Date Date	20c. Location - City	or Town, State
2	rages nent of ont: If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☒ Other (Specify)	lemoval from State	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	orter orter injur		21. Signature of Funeral Service Licens	99	22. Name and Address	ss of Facility	5 W. Baltimor	Charach
ם ח	permit. Pages Department of Importent: If i ony injury or o	ļ.,	Ronald S.	Wade Director	Baltimore,		o w. Baltimor	e Street
***			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ne cause on each line.	ot enter the mode of dyin	g, such as cardiac or respir	atory arrest,	Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death)	Atherosclerotic car		sease		
	/Medical Examiner			Due lo (or as a consequence o	of):			
		_		Due to (or as a consequence o	d)-			
	si a	ine	cause. Enter Underlying Cause (Disease or injury	בי ביון בין כין עם עם מיין בין בין בין בין בין בין בין בין בין	ay.			
	e be executed rsician and e burial-transit	Examiner		c. Due to (or as a consequence of	of):			
1007	oe ex cian ourial	al E		240 10 (01 20 20 10 10 10 10 10 10 10 10 10 10 10 10 10				
20	ate b hysic the b			J				
9	The law requires that the death certilicate in the law requires the late has been signed by the attending physipage 2 should be detached for use as the later.	Physician/Medic	IF FEMALE:					
202	tend tend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death			23d. Date of Month	Day Year
	a dea he at ed fo	sici	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)			
л Э	that the de ned by the a detached	٦ ک	9 ₩ Unknown		U	an in Don't	e. Did tobacco use contribu	te to the cause of death?
Ś	res that igned b	by	Part II. Dther significent conditions co	ntributing to death but not resulting in	ine underlying cause giv	enin Paitt.		Probably 4x Unknown
ב	w requir been si should	Completed by	Hepatitis					
Hecords,	aw re	ple				24	autopsy prio	e autopsy findings available to completion of cause of
Ĭ	The lav	E				15	performed? dea ⊇Yes 2□No 1火	h? Yes 2□No
<u>e</u>	ician: Th certificate rector, pag	O	25. Was case referred to medical			26. Place of Death (Chec	ck onl. one	
Vital	Attending Physician: r death. ector: After this certific. by the funeral director.	To B	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2X ER/Ou	tpatient 3 DOA Oth	er: 4 Nursing Home 5	Residence 6 Other	Specify)
o	y Phys er this eral dii	Į.	27. Manner of Death		Fime of 28c. Injur		escribe how injury occurred	
<u> </u>	nding F th. : After s funer	100	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monny, buy rous)		Yes 2 □ No		
DIVISION	Attendi r death. octor: A by the fu	fice	3 Suicide 6 Could not be	28e. Place of Injury - At home, fa	rm, street, factory, office		cation (Street and Number of ty or Town, State)	or Rural Route Number,
5	after Dire	Certification:	4 Homicide	building, etc. (Specify)			,	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exam	rsician: To the best of my knowledge iner: On the basis of examination and and manner stated.	e, death occurred at the land/or investigation, in my d	me, date and place, and duppinion, death occurred at the	e to the cause(s) and mann ne time, date and place, and	er as staled. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier		29c. Licens	se number	29d. Date signed (#	Month, Day, Year)
	E 3 E 8		0 001	14.5	OCME		February 2	0, 2006
			///-	completed source of death (laser 00-)				,
			30. Name and address of person who d			reat Raltimor	e, Maryland	21201
			Carol Allan, 31. Dale filed (Month, Day, Year)	1000		LCEC DATCIMOL	.c, maryrand	
	St Regis	trar	APR 1 3 200	Post of the	backer			

Brian Dennis Michael Vincent

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

5/14/1 5 6/1/110 1111		- For State Registrar	or maryiana r		ate of Death		Re	g. No.	115,95
Physicia Medical Exami	n/	Decedent's Name (First, Middle,Land)		ichael	Vincent		2. Date of Death Month April 7, 200	Day Year	3. Time of Death 1017 hrs
Wedical Exami		4a. Facility Name (if not institution,		ICHAEI	4b. City, Town,	or Location of D		4c. County of Death	
		2928 E. Monument Stree			Baltimore			NA NA	thplace (State or
Funeral Director		214-76-5503	Sex 7. Age XM 2 F	(In yrs. last bir		ear If Under 2 ays Hours	Min. 8. Date of Birt	Foreig	
any	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
ž .	٦	Md. NA		Ba	ltimore				1 X Yes 2 No
Maryla r 28a-f	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	itry?
s with the Maryland ms 23a or 28a-f sho be notified at once.		2928 E. Monumer	12. Was Decedent	Ever in U.S.	212 13. Was Decedent of F		? (Specify Yes or No-	USA 14. Race - Ameri	ican Indian, Black,
death or ite must	y Funeral	1 X Never Married 2 Marri	ed Armed Forces? 1 Yes 2 ed If Yes, Give Year or Pates:	X No	If Yes, specify Cub	pan, Mexican, P		White, etc.	inadad
hours a	ed by	15. Decedent's Education (Specify			Decedent's Usual Occup during most of working I			16b. Kind of Business/I	ndustry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or 5) +)	Housekeepi	ng		Hospital	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		17. Father's Name (First, Middle, La			incent	18.Mother's I	Name (First, Middle, M		oods
2121 2121 ould be fi Mental marked c event,	To Be	Ashby 19a. Informant's Name/Relationship			Db. Mailing Address (Str		The state of the s		
MD ;		Shelia Vincent	Motl		2928 E. Mon				
more, MI Pages 1 and 2 sent of Health a		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta	ate crema	of Disposition (Name of tory or other place)		Date	20c. Location - City or	
Baltimore, permit. Pages I ar Department of Hes Important: If ite		4 Donation 5 Other Spec 21. Signature of Funeral Service Lic		Oak	Lawn Cem.		4-14-06	Baltimore	21202
Balti permit. Departm Imports injury o		Mlade W	one		March F	-	t 1101	more, Md. E. North A	ve.
Physician		23a. Part I. Enter the disease, or co failure. List only one cause on		the death. Do r	not enter the mode of dyir	ng, such as card	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical ≒xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Narcotic (M) intoxication				Death
		Sequentially list conditions,	b						
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse c.	equence of):					9.
ted 1 Insit	Examiner	events resulting in death) Last	Due to (or as a conse	equence of):					
760, icate be executed physician and the burial - transit	ledical	X UNPENDED	X AMENDED ite	am#23a,27	,28b-f,perME,g	854,4/24	/06 TT	- ··-	
760, ficate be g physic the bur	₹	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor	ne of pregnancy	7 Fetal death	3 Ectopic p	pregnancy	23d Date of deliver	y Day Year
30x 68 death certif	Physician	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at	time of death	5 Other (Specify)			H.	
he he	Phys	Part II. Other significant condition	9 OHKHOWH	h but not resulti	ng in the underlying caus	se given in Part	I. 23e. Did to	bbacco use contribute to	the cause of death?
Records, P.O. I The law requires that the cate has been signed by th page 2 should be detache	d by			<u> </u>			1 Yes	s 2 No 3 Pro	bably 4 Unknown
Records The law requirecte has been apage 2 should	Completed				·		24a. Was autop	prior to	utopsy findings available completion of cause of
tal Reconstant: The late certificate ha	Som						1 🗸 Yes		es 2 No
Vital ysician: his certifi director,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	ent 2 ER/	26.PI Outpatient 3 DOA	Other	Nursing Hame 5	Residence 6 🗸 Othe	er: Scene
of Viring Physical After this Cuneral dir	n: To	1 V Yes 2 No 27. Manner of Death	28a. Date of Inju	iry 28b		Injury at Work?		how injury occurred	
Sion tttendi death ctor:	atio	1 Natural 5 Pendin 2 Accident Investig	gation Apr 7, 2006	10	00 hrs	Yes 2X N	29f Location (Street and Number or R	ural Pauta Number City
Division of Vital Records, P.O Hospital or Attending Physician: The law requires that the Anours after death. Funeral Director: After this certificate has been signed by tely filled in by the funeral director, page 2 should be detac	Certification:	3 Suicide 6 X Could determ	not be		farm, street, factory, office dence	se building, etc.	or Town, S , Baltimore,	State)2928 E. Mor MD	ument St.
Division of Vital B Vi	Medical Co	29a. Certifier 1 Certifying Phy	iner:On the basis of exa	ny knowledge, d mination and/o	eath occurred at the time	e, date and plac nion, death occu	e, and due to the caus	se(s) and manner as sta	rted
To will	Me	29b Signature and title of certifier	and manner stated.	$H\Lambda$		ense number		29d. Date signed (Mo	
		- VAS	1/	0		C.M.E.		APRIL 1	3,2006
		30. Name indiaddress of per in was Assistant Medical Ex	1 1) Baltimore, MD 2120)1			
	tate		2006 32. Registra	ar's Signature	1. 10.				
Regis		10	2000	WARD A	RIGINAL				
DHMH 17 Rev 1/	LUUT			U	NIGHNAL				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year **Physician** ALEXANDER WANEK 12:05 PM 04 10 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1XM 2□F 86 Director 220-03-9254 Auq. 17, 1919 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Modical Exemitrer must be notified at 1 ☐ Yes 2 🕱 No Dundalk Director Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6733 Oak Ave. 21222 USA 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. "natural", or itama Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be fitted within 72 hours after to Department of Health and Mental Hygiene. I important: If tiem 27 Is marked other than "natural", or flar any injury or other traumatic event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) 7 yrs. Furnace Mechanic Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Christian Vanek Catherine Plonk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 6733 Oak Ave. Dundalk Md. 21222 Ella Wanek 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Sacred Heart of Jesus April 13 1X Burial 2 Cremation 3 Removal from State Dundalk 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licenta Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10ars /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2 110 il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 10,2006 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person DR. MANUEL LAZATIN, 8 LAW STREET, ABERDEEN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

06-01715 d1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene																		
a			for State Registrar		St	ate of	Marylar				lealth a D <i>eath</i>	ind Me	ental Hy	gien Reg. N	2000	5	11588	
	Physici	an	1. Decedent's Name Katie M	e (First, Middle lae Yo	der							1	2. Date of D Month March	eath		ear	3. Time of Death 4:50 P M	1
200	/Medic Examir		4a. Facility Name (/		_	and numb	oer)				Location of		ICIL CIT	40	c. County of	Death	4.50 1	
	Funeral		501 Zehne	umber	6. Sex	7.		last birthday)		ntsvi er 1 Year s Days	If Under 2 Hours	24 Hrs. 6	B. Date of B		arrett	. Birthp	lace (State or Foreign	n
	Director		192-66- Usual Residence of		1 □ M	2.12(F	35	Yrs.	WOTE	Days	Hours	IVIII.	May	5, 5	1970	Ē	Ã	-
	Manyland f ahow	ō	10a. State MD	10b. County	Garı	rett	10c. Ci	ity, Town or Lo	cation	Gr	ants	vill	e			1	0d. Inside City Limits 1 (2) Yes 2 (2) No	
	with the 1 3a or 28a-	i Direct	10e. Street and Nur 501 Zeh		.d				10f. 2	ip Code		2153	6	10g. C	itizen of Wha	t Cour	•	
920	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "natural", or itema 23a or 28a-1 ahow avent, the Mudical Examinar must be profiled at	Completed by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed		ned 1	/as Decedomed Forc ☐ Yes 2 Yes, Give ear or Date	∐*No				ispanic Orig in, Mexican, Specify:	in? (Spec Puerto Ri	fy Yes or N can, etc.)	0-	14. Race - Black, Specify:		etc.	
21215-0036	in 72 ha n "natur dedical	pietec		15. Deceden	st grade con	npleted)		16a. Dece (Give life.	dent's Us kind of v DO NOT	sual Occupa vork done d use retired	ation during most	of working		16b. l	Kind of Busin	ess/Ind	dustry	
212	filed with Hygiene. Ither ther	Com	Elementary/Seco			ollege (1-4	or 5+)		F	Iomen	aker					C	wn Home	
land	2 should be filed within and Mental Hygiene. Is marked other than aumatic avent, the Mental control of the Men	To Be	17. Father's Name	rey G.		der							First, Middle B.		n Sumame) P r			
Maryland	2 = 2 = E	-	19a. Informant's Na Clarer				Husb	19b. Mailii and 50							or Town, Sta Le MD			
Baltimore,	Pages 1 and nent of Health snt: If Item 27 ary or other tr		20a. Method of Disp 1 Burial 2 4 Donation	Cremation	3 Remo	val from St	242	Place of Dispo cemetery, crei	matory of	other plac		. Ma			ocation - Cit		wn, State	F
Baltii	permit. Pages Depertment of Importent: If I any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave. Baltimore MD 21230															
	Physician		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death Onset and Death															
	/Medical Examiner		resulting in death)	- 414		Due to (or	as a consec	querge of):	W (Pro	sa-bo	se						
	uted d ansit	Examiner	Sequentially list confidence if any, leading to imcause. Enter Unde Cause (Disease or that initiated events	nditions, mediate rlying injury	l "-	Due to (or	as a consec	quence of):										
,092	death certificate be executed e ettending physicien end ad for use as the burial-transit	-	resulting in death) l		d	Due to (or	as a consec	quence of):										
ox 6876	entificate ding phy se as the	/Medic	IF FEMALE:			ves outco	me of pregn	2004										
P.O. Bo	0 0	Physician/Medica	23b. Was decedent in the past 12 12 Yes 2 D Unknown	months?	1	ive birt	h 2 ☐ Feta nt at time of d	al death 3[Ectopic Other (pregnancy specify)					23d. Date of Month	f delive	Day Year 7 2506	
	uires that signed b	þ	Part II. Other signif	icant conditio	ens contribu	ting to dea	th but not res	sulting in the u	nderlying	cause give	en in Part I.						e cause of death?	
al Records,	icien: The law requires that the certificate has been signed by th rector, page 2 should be detache	Completed											1 Yes	opsy ormed? 2 \Begin{array}{c} No	prior	r to con th?	osy findings available npletion of cause of	,
f Vital	W 17	To Be	25. Was case reference examiner?		Hospit	al: 1 🗆 Inp	patient 2	ER/Outpatier	nt 3 🗆 [Othe			Check only 5 ☐ Res		6 ☑Other (Specify	scene	
ion of	D je G		27. Manner of Death 1 Natural 2 Accident	5 🗌 Pendin investi	g	a. Date of (Month,	Injury Day Year)	28b. Time of Injury	M	28c. Injury Work		28			iry occurred		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	_
Division	2 8 2 2	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ		e. Place of building	f Injury - At h , etc. (Speci	ome, farm, str fy)	eet, facto	ary, office		28	f. Location City or To	(Street a	nd Number o	or Rura	Route Number.	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical (29a. Certifier (Check only one)	1☐ Certifyin 20 Medical	Examiner: (t: To the bas on the bas and manne	is of examina	owledge, deatl ation and/or in	n occurre vestigation	d at the time in, in my op	ne, date and pinion, death	place, an	d due to the at the time	cause(s , date an	s) and manne od place, and	er as st	ated. the cause(s)	_
	- /	X	29b. Signature and	title of certifie	0.0	1	\wedge			9c. License	number				ate signed (A			
	ia		30. Name and addr	ess of person	who comple	ted cause	of death (Ite	m 23a) (Type,		OCME_				Marc	h 10,	200)6	
	\ 		31. Date filed (Mon	Hon	rloc	KE,	m)		111	Penn	Stre	et, E	Baltim	ore,	Mary	land	1 21201	
	Sta Registr		AF		2006	Clare	istrar's Sign	ature	A.S									

DHMH 17 Rev 1/2001

Claude Arnold Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-02227 Amend unpend item#123a 27 Mary and Department of Health and Mental Hygiene crn 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Claude Arnold, Jr. Claude Arnold 28 2006 Р /Medical March 8:544a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville
If Under 1 Year If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) 05-27-1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑**M 2□ F 67 577-50-0978 Yrs. Director Washington, D.C Usual Residence of Decedent Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits rel', or iteme 23a or 28a-f ehor Examiner must be notified at D.C. Washington 1X Yes 2 No Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2520 12th Street, N.W. 20009 U.S.A. filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2X No Ď Specify: Black 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed other then "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Popeyes Utility Worker 17 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be and Mental Claude Arnold, Sr. Ida Curly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $2520\ 12th\ Street,\ N.W.$ Washington, D.C. 2000919a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Depertment of Health ar important: If item 27 ie eny injury or other trau once. Irun M. Warner/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 04-08-2006 4 ☐ Donatton 5 ☐ Other (Specify) Beltsville, Maryland 21. Signatura of Funeral Service License 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, D.C. 20010 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart sailure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Congestive Heart Failure complicated by Acute Renal Failure /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): SH or Attending Physicien: The law requires that the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of): O. Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? death? Ves 2□ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Tyes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3□ DOA SiQ! 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

State Registrar

K. HC Date filed (Month, Day, Year) APR 0 7 2006

(Check only one) 29b. Signature and title of

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

completely

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

April 02, 2006

			For State Registrar	State of Marylan		artment of H tificate of L			ene 006	11590
	n		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	3. Time of Death
	Physici /Medic		Charlotte	Elizabetl	h	Autr		March	23 200	
	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of D	
Е			4996 Lerch Drive		Inct histhday)	Shady Si	de If Under 24 Hrs.	8. Date of Birth	Anne Ar	
	Funeral Director		5. Social Security Number 6. Sex 10	7. Age (In yrs.		Months Days	Hours Min.	June 26	Year) V	Birthplace (State or Foreign Country) 'irginia
			Usual Residence of Decedent					oune 20,	, 1 J 1 J	11611111
	yland		10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
:	a-i-e	tor	MD Anne Arur	ide1	Shady S	Side				1 ☐ Yes 2 ☐XNo
	or 28	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of Wha	•
	23a	ral	4996 Lerch Drive			207			USA	
	er de	Funeral	11. Wallar Oldes	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		American Indian, Vhite, etc.
3	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 【XWidowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1□Yes 2XNo	Specify:		Specify:	White
3	s hou		15. Decedent's Educ	cation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busin	ess/Industry
2	hin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	luring most of won)	ang		
7	d with	E O	Clariditaly/observatory (5 12)		Secre	tary				overnment
2	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)					e (First, Middle, A		
Z Z	Ment Ment arkec	ဥ	George Bulger					th A. Car		
5	2 sho and is m		19a. Informant's Name/Relationship (Ty)			ng Address (Street a				te, Zip Code)
ב ה	l and lealth im 27 ther t		William Autrey (C		-	Riva Roa) 20c. Location - City	or Town. State
5	ges of of the state of the stat		1 Burial 2 □ Cremation 3 □ R	emoval from State		nsition (Name of matory or other place	!			
aitillio	it. Pa rtmer rtant njury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License			Vet. Cem		7–2006	Crownsvi	.IIe, MD
0	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show empting or other treumatic event, the Medical Examinar must be invitted at once.		13- 2.Ch		-	Name and Address Hardesty	Funeral	Home, P.	A. olis, MD	21.601
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea	th. Do not en					Approximate Interval Between
	certificate be executed had been seen the prize as the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	quence of):	rofic,	Henrt	Dise	45 C	
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ŏ	rtificat ng phy s as th		IF FEMALE:							
O. DO.	atter for u	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	f delivery Day Year
, co	w requires that the de been signed by the a should be detached	٥	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.	23e. Did tot		te to the cause of death? Probably 4 Unknown
ב	e ta has	Completed						24a. Was a autops perform	y prio ned? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
N I G	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on		
<u>-</u>	Physic this ce al direc	10	1 Yes 2 No		ER/Outpatie		4 🗆 14 di Silig 11		ence 6 Other	(Specify)
5	ding Ph h. After thi funeral		27. Manner of Death 1 ☑Netural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe ho	w injury occurred	
2	Attending Physician: ir death. ector: After this certific by the funeral director.	cati	2 Accident Investigation 3 Suicide 6 Could not be		<u> </u>		Yes 2 □No	206 1 10 100		0.00
DIVISION	after d after d Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury · At h building, etc. (Speci	nome, farm, st ify)	reet, factory, office		City or Town		or Rural Route Number,
_	Hospita 4 hours Funeral	edical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	lowledge, deal	th occurred at the tin	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mainer stated.		29c. Licens)	9d. Date signed (A	
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			30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type	, Print)			3/24 Rd 20	
			William P. J	TONES MI	0 6	131 51	hady:	Side 7	Rd 26	764
Ŷ	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 8 200	32 Registrar's Sign			(

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 24, 6:30 p^M 2006 Mar. George Joseph Becker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 1089 Deep Creek Avenue Arnold If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 19,1916 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1⊠M 2□F 90 212-10-8294 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "naturel", or iteme 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 No Director Arnold Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21012 1089 Deep Creek Avenue Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 10. Black, White, etc. 1947-IXYes 2 ☐ No IYes, Give 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: USA 1952 ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Aberdeen Proving Cotlege (1-4or 5+) Elementary/Secondary (0-12) Grounds Machinist 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental F 7 Is marked of Mary Amelia Yeakle George Leo Becker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ent: If item 27 le 925 South Conkling St., Baltimore, MD Philip Kueberth/Cousin Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Mar. 29, 1 Surial 2 Cremation 3 Removal from State Depertment o Importent: If any injury or once. New Cathedral Cemetery Baltimore, MD 4 □ Donation 5 □ Other (Specify) 2006 Barranco & Sons, P.A. Severna Park Funeral Home 21. Signature of Funeral Service Linen. 495 Gov. Ritchie Hwy, Severna Park, MD 21146 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause in each line. 3a art1. Ent - the disease, or co shock, or eart failure. List of mmediate Ca se (Final disease or condition resulting in eath) ~ 103clerofic HEART INTO Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, tany leading Lambadians cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day 4☐ Pregnant at time of death 5 Other (specify) signed by the 6 Id be detached f P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an cete hes t page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner?
1 Dores 2 □ No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 51 Sesidence 6 Other (Specify) ۵ this After this funeral of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death.

Director: All investigation 2 Accident 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 5 29c. License number 0 6 0 5 4 29d. Date signed (Month, Day, Year) Deputy 29b. Signature and title of certifier 695 America 21036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jones, mo 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2006 Registrar

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	Discontinu	Yang	Decedent's Name (First, Middle, Last)		2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Roy D. Burns			28, 200		12:03 A M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County		
× 7	A Company	1	2918 Tallow Lane	Bowie If Under 1 Year If Under 24 Hrs.	T =	Prince		
V.	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 329-30-4342 7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birt (Month, Da 03/16/	h Y. Year) 1916		lace (State or Foreign htry) uori
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	r 28a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of \	What Cour	ntry?
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36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "natural", or Itama 23e or 28a-1 show event, I're Medical Exardian must be notified at	by Funeral	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🏿 No Specify:	ecify Yes or No Rican, etc.)		ck, White,	
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yla	2 should be and Mental is marked o	2	Matthew Edwin Burns	Carrie Be				
Maryland 21215-0036	12 sh n and n is m raum			mg Address (Street and Number or Run			State, Zip	Code)
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked ent injury or other traumatic enter in the page.		1 Burial 2 □ Cremation 3 □ Removal from State Cemetery, cree Mar	natory or other place)				
Ħ	artme ortan injur	1	4 □Donation 5 □Other (Specify) Veterans 21. Signature of Funeral Service Licensee 2:	Cemetery 03/3 Name and Address of Facility Rob	1/2006_	Crownsy	ille,	MD 1 Home
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			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)				
			Francine A. Higgs-Shipman, MD 11700	Beltsville Drive E	Beltsvil	le, MD	20705)
	Sta Registr		31. Date filed (Month, Day, Year) ARR 2 9 2006 Registrar's Signature	will be				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March Olga Kowall Bylen 27 2006 12:36 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Sept 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year 1□ M 2 🙀 F 218-42-8416 82 Director 1923 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Mudical Examiner must be notified at MD Carroll Westminster 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 1523 Hughes Shop Road USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【No Specify: White Completed by Specify: 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Williams & Wilkens Elementary/Secondary (0-12) College (1-4or 5+) 9 Medical Publishers Publishing Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Timofave Kowall Jenovia Lazaruk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Heelth at important: if item 27 ie any injury or other traugonce. Katherine Garrett/daughter 1523 Hughes Shop Road Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/31/2006 Holy Cross Cemetery Brooklyn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P.A. W 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** m med /Medical Due to (or as a consequence, Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number e of death (Item 23a) (Type, Print) Dr. Philip J. Ruzbarsky, 2 31. Date filed (Month, Day, Year) 32. strar's Signature State Registrar 2006

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Physician (Medical Examiner) Physic	B	Dan Park		(A) JAHAD			D	ANZA	NSKY-	GOLDBER	G MEMORI	AL CHAPELS	, INC. YLAND 20852
Physician Medical Examiner The control of the co				23a. Part I. Enter the disease, or comp	olications that cause	ed the death	n. Do not ent	ter the mo	de of dying	, such as cardi	ac or respiratory a	arrest,	Approximate Interval Between
Sequentially list conditions, darw, leading to immediate clause. Enter Underlying that initiated events resulting in death) Last Sequentially list conditions, darw, leading to immediate clause. Enter Underlying that initiated events resulting in death) Last Sequentially list conditions, darw, leading to immediate clause. Enter Underlying that initiated events resulting in death) Last Sequentially list conditions, darw, leading to immediate clause. Enter Underlying that initiated events resulting in death) Last Sequentially list conditions, darw, leading to immediate clause. Enter Underlying that initiated events resulting in death) Last Sequentially list conditions, darwing the light list death of the clause o		Physician		Immediate Cause (Final	COL	RON	AR	Y F	RI	FDY	DISE	MSE	Onset and Death
Sequentially list conditions of the country of the					Due to for as	s a consequ		=in/	(10	11			
ODUST THE TOTAL CONTROLL THE STATE OF THE ST	п	Examiner		Sequentially list conditions,	b. # 4	PO	RIE	IV	510	00			
ODUST THE TOTAL CONTROLL THE STATE OF THE ST		led sit	nlne	cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	dence of):						
Temporary Temp	•	al-tra	Exar	that initiated events	C. Due to (or as	s a consequ	uence of):						-
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The state of the s	9	tificat ng phy as th											
The state of the s	XOX	th cer tendir rr use	an/h	23b. Was decedent pregnant				Ectopic i	огеопапсу				
The state of the s		e dea the at ned fo	sici	1 ☐ Yes 2 ☐ No	4☐Pregnant a							Month	Day Year
25. Was case referred to medical examiner? 1		hat th od by detach			ontributing to death (hut not resi	ulting in the u	nderhina	Carre Cine	n in Part I	23e Did	tobacco use contribute	to the cause of death?
25. Was case referred to medical examiner? 1	ds,	signe d be d	d by	SENILE I	DEME	\mathcal{I}	7/14	Johnying	cause give	ir iii r dici.		1 /	Probably 4 []Unknown
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25. Was case referred to medical examiner? 1	Re	he lay	шc								auto	ormed?// death	? . /
The state of the s	tal			25. Was case referred to medical			-			26 Place of D	-		es 20 No
Solution Street and Number or Rural Route Num State Street and N	<u> </u>	ysicii is cer direct		examiner?	Hospital: 1 Inpati	ient 2	ER/Outpatier	nt 3 🗆 🗅	OA Othe				oecify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0	ng Ph Itar th			28a. Date of Inju	ury ay Year)		f	28c. Injury Work				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Sio	eath. or: Ay	catio	2 ☐ Accident investigation									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Σ̈́	or Att	ıtili	determined	28e. Place of in	ijury - At ho itc. <i>(Specif</i> y	me, farm, str /)	eet, facto	ry, office		28f. Location (City or To	(Street and Number or wn, State)	Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ours a ours a erai f		29a Certifier 1 Certifying Phy	veician. To the hest	t of my kno	wledge deat	h occurre	d at the tim	e date and place	ce and due to the	cause(s) and manner	as stated
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		P Hon	dica	(Check only 2 Medical Exam	iner: On the basis of	of examinat	tion and/or in	vestigatio	n, in my op	inion, death oc	curred at the time,	date and place, and d	ue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		withir To th	Me	29b. Signature and title of certifier	16	1///		29	c. License			at the second se	
				> / Jone Okieli	~ R	Will	ly	Mp.	7	354	36	MARCH E	4,2006
DR. BARBARA KALAZNY. 6121 MONTROSE ROAD, ROCKVILLE, MARVIAND, 20852		1											
as Day Clark March Day March				DR. BARBARA KALAZ	1 00 00		_			/ILLE, I	MARYLAND	20852	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature			-	MAR 2 9 2	1006 32. Hogist	irai s oigna Bland - A	de de	make	p				

		-	For State Registrer	te of Maryland	-	rtment of H			iene _{eg. No.} 006	1 5	96
	Physicia	-2010	1. Decedent's Name (First, Middle, Last) Leonie V. Bak	rer				2. Date of Dea Month	th Day Ye	3. Time of	
	/Medic Examin		4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location of Deat	March	25, 20 4c. County of I	00	
	Lxamm	Çı	National Lutherar	Home		Rockvi1			Montgor		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. las 79	st birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.			Birthplace (State of Country) Vew York	or Foreign
	ס	-	Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Loc	antion		ban. 57	1321 1	10d. Inside C	ity t imits
	Maryla f shov	JO.	Maryland Montgomery		nesda	ation					2 □ No
	h the h	lrect	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	it Country?	
	ath wit	raiD	5724 Bradley Blvd.			208			United S		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy njury or other traumatic evant, the Medical Examinat must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces?]Yes 2⊠No 'es, Give ar or Dates:	1	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. Vhite	
5-0	"natur	leted	15. Decedent's Education (Specify only highest grade comp	pleted)	(Give i	ent's Usual Occupa kind of work done of OO NOT use retired	luring most of wo	rking	16b. Kind of Busin	ess/Industry	
21215-0036	d within jiene. r than	Completed	Elementary/Secondary (0-12) Co	llege (1-4or 5+)		stered Ni			Medica1	L	
pu	2 should be filed w and Mental Hygie is markad othar t raumatic evant, II.	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Sumame)		
Maryland	hould id Men marka matic	10	Pieter C. Vosburgh 19a. Informant's Name/Relationship (Type, Pn	nt)	19b. Mailin	g Address (Street a	Alice		r, City or Town, Sta	ite, Zip Code)	
	and 2 sealth an n 27 is		Edward Tate Baker/Hus			Bradley H			-		
Baltimore,	Pages 1 annount of He ant: If itam ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova	20b. Pla	ce of Dispos netecy, crem Wash	sition (Name of natory or other place Univers	Marc Sity 20	h ^{Da} 26	20c. Location - Cit		
III III	it. Pag intmend intent:		* 4 ☑Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee		cal C	enter	- 1		ortuary S	con, D.C.	Tna
Ba	permit. Departr Importu any inji		1) Must 2 Der	lan					on, D.C.		IIIC.
8760,	Physician physician and physician and physician and physician and physician and physician the physician ph	dical Examiner	Saquantaily list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	epce of):	grafor Grafor Festiv	Lull Lull	aller Localin	9	Approxima Interval Be Onset and	tween
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s, P	sign d be	by	Part II. Other significant conditions contributi	ng to death but not resul	ting in the ur	nderlying cause give	en in Part I.		bacco use contribu		
Il Record	The law ate has b page 2 s	Completed						24a. Was a autop perfor 1 \(\text{ Yes} \)	sy prio med? dea	re autopsy findings ir to completion of c th? Yes 2 \sum No	
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ıl: 1 □ Inpatient 2 □ E	R/Outpatien	t 3 DOA Othe	200	ath (Check only or	ence 6 Other	(Specify)	
J Of		H-1			28b. Time of Injury	28c. Injury Work	at		ow injury occurred	(оровну)	
Division	if or Attanding Patter death. Diractor: After id in by the funer	Certification:	2 Accident investigation	o. Place of Injury - At hon building, etc. (Specify)	ne, farm, str		Yes 2 □ No	28f. Location (S City or Tow	itreet and Number (n, State)	or Rural Route Nur	nber,
	To tha Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by	edical C	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: O								s)
)	To that	Med	29b. Signature and title of certifier	aresh-	0	29c. License	1726	V	29d. Date signed (1)	Month, Day, Year)	6
			30. Name and address of person who complete Charles W. Karesh		23а) (Туре,	2,01	Veirs D			_	
	Sta Regist		31. Date filed (Month Day Year) MAR 3 0 2006	32. Pegistrar's Signatu	Jre A	ade					

State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 3 **Physician** 26-2006 Timothy Barrett Cyrus /Medical 4b. City Town, or Location of Death cility Name (If not institution, give street and number) 4c. County of Death Examiner Spic 6. Sau alisbur ICOMICO 0 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y June 27 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1**X**M 2□ F Yrs. 128-20-1103 N.Carolina Director 1928 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at 1 Tyes 2 No Director Mardela Maryland Wicomico Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9499 Athol Road 21837 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status l □ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XNo þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any Injury or other treumatic event once. Elementary/Secondary (0-12) College (1-4 or 5+) 11 Truck Driver None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lee Barrett Minnie Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9499 Athol Rd.Mardela Springs, Md. 21837 Rhoda Barrett (Wife) Date 3/3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Springhill Mem Garden 4 □ Donation 5 □ Other (Specify) Hebron, Md. Stewart Funeral Home 821 West Rd.Salisbury,Md.21801 21. Signature of Funeral Service Licensee Gladys 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine nding physicien and use as the burial-transit To the Hospitei or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۵ 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed: 22 No 1 Yes 1 🗌 Yes of Vital after death.

Director: After this certific
J in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 176378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 733 HUSPILL 32. Registrar's Signature State 0 2006 Sperti Registrar

The law requires that the death certificate be executed n signed by the a d be detached fo Division of Vital Records, P.O. has been si r this certificate h Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifi Director: To the I To the

21:45 If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Foreign Delaware 10d Inside City Limits 1 Yes 2 y No 10a. Citizen of What Country? United States 14. Race - American Indian, Black, Specify: White 16b. Kind of Business/Industry Retail Petroleum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 University Drive, Newark, Delaware 19713 20c. Location - City or Town, State West Chester, Pennsylvania 21 Signature of Funeral Service Licensee

22 Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approximate Intervi-Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other: A Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Subject asphyxiated self **FOUND** 1 Natural Yes 2 V No Pending Apr 5, 2006 21:45 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 1000 Knights Island Road, Earleville, MD (Specify) Garage determined Homicide 4 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Sigr 29c. License numbe O.C.M.E. April 6, 2006 30. Name and address of person who cor pleted cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 2006

ORIĞINAL

Registrar

DHMH 17 Rev 1/2001 OCME 10/2003

			For Stata Registrar	State of Mary		artment of F			iene 19. No. 0 0 6	11599
	Physici		1. Decedent's Name (First, Middle, Last) Leonard A. Blac	kshear				2. Date of Deat Month March		3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give s 2705 Riva Rd.	treet and number)		Annap			4c. County of Dea	th
1	Funeral Director		5. Social Security Number 6. Sex 069-34-3239 1 1 Number 1	7. Age (In	yrs. last birthday) 62 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, June 29	9. Bir 1943 Ge	thplace (State or Foreign puntry) Orgia
	e Maryland la-f show	ctor	10a. State 10b. County Maryland Anne Ar		c. City, Town or Lo Annapol					10d. Inside City Limits Ñ∭Yes 2 □ No
	ath with th	Funeral Director	10e. Street and Number 2705 Riva Rd.				401		og. Citizen of What Co	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show styl houry or other traumatic event, the Medical Examinar must be maillied at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes ZE No	dispanic Origin? (Spe an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	e filed within 72 ha al Hygiene. I other than "natur vent, the Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give	dent's Usual Occup kind of work done DO NOT use retired SINESS	during most of worki d)	ng	ele Commi	Unications
Maryland 2	should be filed ind Mental Hygi smarked other umatic event,	To Be Co	17. Father's Name (First, Middle, Last) Frank A. Blacks	*			18. Mother's Name Elsie S	(First, Middle, A	faiden Sumame)	
	1 and 2 sho Health and I Iem 27 Is mu		19a. Informant's Name/Relationship (Type Patsy B. Blacks)	hear(Wife) 2705	Riva R	d. Annap	olis,	City or Town, State, Md. 2140	1
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 Burial 2 XCremation 3 Re 4 Donation 5 Other (Specify)	sinoval floir State	ob. Place of Dispo cemetery, crer Metro C	remator	у 3-29	-06	20c. Location - City or Baltimore	e, Md.
Ba	Dermi Depa Impo			Peese Mca	783 8	21 West	St. Ann	apolis	ary, P.A , Md. 21	101 Approximate
ja.	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	2 /	TILIK	t	,		Interval Between Onset and Death
	rate be executed can be executed by sician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of)	PABY Z M	Flong	<u>ź</u>		12/2000
68760,	tificate be executed og physician and as the burial-transit	ical	L d							
P.O. Box	Attending Physician: The law requires that the death certific rideath articles that the certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	ý		23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant conditions conf	tributing to death but no	nt resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to s 2 No 3 □ Pi	o the cause of death? robably 4 [Unknown
al Records,	ician: The law n certificate has be ector, page 2 sh	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of 2 No
of Vital	Physician: The this certificate ha al director, page	To Be	1 195 290 NO		2 ER/Outpatien		4 Nursing nor		nce 6 □Other (Spe	cify)
Division of	r Attending P er death. rector: After I by the funera	Certification:	27. Manger of Death 1 Natural 5 Pending investigation 3 Surcide 6 Could not be	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe ho	w injury occurred	
<u>></u>			4 Homicide determined	28e. Place of Injury - building, etc. (S	pecify)			City or Town		
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medicai	(Check only 2 Medical Examin one)	ician: To the best of my er: On the basis of exa and manner stated.	mination and/or inv	vestigation, in my o	pinion, death occurre	ed at the time, da	te and place, and due	to the cause(s)
	Will To		29b. Signature and title of certifier	foods	MJ	29c. Licens	0/06 97	9	nd. Date signed (Month MARCH 2 MATCH M	n, Day, Year)
			30. Name and address of person who ce	ent mi	3 /6/6	Print	PRIJE	AND	potis m	211403
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 200	6 Registrar's S	Signature	A.				

			1 - For State Registrar	State	of Maryla		artment of ertificate of				iene	6	1160	0 (
	Physic	ian	Decedent's Name (First, Midd.	(e, Last)	_					2. Date of Dea Month	th Day	Year	3. Time of	
	/Medi	cal	Gertrude		C.		Barnes			March		06	9:05	a M
pin .	Examir	ner	4a. Facility Name (If not institutio Genesis Elder		,	D1	4b. City, Town,				4c. County			
<u>ģ</u> .	2		5. Social Security Number	6. Sex		Park s. last birthday		erna]		0 Day - (D) 41		Aru		
	Funeral Director		111-09-5665	1 M 2 X F		89 Yrs.	Months Days		Min.	8 Date of Birth (Month, Day Nov • 20	Year)	Coun	lace (State o	r Foreign
	200		Usual Residence of Decedent							NOV. 20	, 1910	Mew	York	
	yland		10a. State 10b. County		10c. C	City, Town or L	ocation					1	Od. Inside Ci	ty Limits
	Mar	to	MD Anne	Arunde1		Annapo	lis						1 🗆 Yes	Ž₽ No
	h the	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of W	/hat Coun		211
	38 o		3100 Ervin Co	urt			214	O3			USA		,	
	deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decedent of If Yes, specify Cut		gin? (Spe	cify Yes or No-	14. Race		an Indian,	
9	or Ite	Ē	1 Never Married 2 Mar		2 X No				n, Puerto	Rican, etc.)	Black	k, White,	_	
ဗ္ဗ	rel',	þ	3XXVidowed 4 ☐ Divorced	If Yes, G Year or I	Dates:		1 ☐ Yes 2 🛣 No	Specify:			Specify:		White	
21215-0036	72 h	Completed	15. Deceder	t's Education st grade completed	1		dent's Usual Occu		t of undi	200	16b. Kind of Bu	siness/inc	dustry	
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7	ygier ygier t,	Co	12			Homen	aker				Own H	ome		
밀	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "naturel", or iteme 23s or 28e-f show event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle, I	Maiden Sumame	э)		
<u>ya</u>	ould Men arke	2	Charles Fox					Joha	nna	Boes				
Maryland	2 sh and is m		19a. Informant's Name/Relations			19b. Maili	ng Address (Stree	t and Numbe	er or Rura	il Route Number.	City or Town, S	State, Zip	Code)	
	and ealth m 27		Jim Barnes (S	on)			0 Ervin	Court,			MD 214	03		
Ore	of H		20a. Method of Disposition 1 ☐ Burial 2XXCremation	3 □Removal from		Place of Dispi cemetery, cre	osition (Name of matory or other pla	ice)	D	ate	20c. Location - (City or To	wn, State	
Ē	Pag ment ant: ury c		4 Donation 5 Other (S			etro Cr	ematory	1	3-28	2006	Baltimo:	re, N	1D	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28e-f ehow with injury or other traumatic event, the Wadinal Examinal must be notified at ance.		21. Signature of Funeral Service	Licensee		2	2. Name and Addre	ess of Facilit	y	Home, P				
_	70 E 2 9		77- 7.6	- Con-			12 Ridg	ely Av	renue	Annap	olis. M	D 214	401	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the dea	th. Do not en	ter the mode of dyi	ng, such as	cardiac o	r respiratory arre	est,		Approximate Interval Bety	ween
	Pnysician		Immediate Cause (Final disease or condition	1+0	IVa	nco	A AI	7hi	011	ner.	= don	non	Onset and D	eath
	/Medical		resulting in death)	Due to	(or as a conse	quence of):	an and				0 011	1837	1700	Zeus
	Examiner		Sequentially list conditions	b										
	D #	Examiner	Sequentially list conditions, it any, reading to immodiate cause. Enter Underlying Cause (Disease or injury	Due to	(or se a conce	quence of):								
	and trans	am	that initiated events resulting in death) Last	c										
30,	cate be executed physicien and the burial-transit		rosuming in dodary cust	Due to	(or as a conse	quence of):								
8760,	physic the b	dical		d					_			-		
9	entific ling p	Me	IF FEMALE:	1										
Вох	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		tcome of pregr pirth 2 Tet		Ectopic pregnanc	y			23d. Date Mon			
0	at the de by the a tached f	sic	1 ☐ Yes 2 N No 9 ☐ Unknown	4☐Preg 9☐Unkr	nant at time of own	death 5[Other (specify) _				MOIT	LII I	Day Y	'ear
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Ś	res ti signe be d	by	Part II. Other significant condition	Ais contributing to c	eath but not re	suiting in the u	nderlying cause giv	ven in Part I.			acco use contri			
ecords,	w require been si should t	Completed						-		1 ☐ Ye	s 2 No 3	3 🗌 Proba	ably 4	mxnown
Ö	law law as b	ple								24a. Was ar autopsy		ere autop	sy findings a	vailable
r		20								perform	ned? de	eath?		u36 0i
Vital	o, iji	Be (25. Was case referred to medical examiner?		,			26. Place	of Death	(Check only one				
5	Physicion this certail	2	1 ☐ Yes 2 ☐ No			ER/Outpatier	nt 3□ DOA Ott	ner: 4 Thur	rsing Hon	ne 5 🗆 Reside	nce 6 Other	r (Specify))	
	Jing Ph I. After th funeral	.io	27. Mann Death 1 Natural 5 ☐ Pendin	28a. Date (Mor.	of Injury th, Day Year)	28b. Time o	f 28c. Inju	ry at rk?	2	8d. Describe ho	w injury occurre	d		
<u> </u>		catl	2 Accident investig	ation				Yes 2 1	40					
Division	# 0 0 >	Certification:	3 Suicide 6 Could a determination	ined 288. Place	of Injury - At h	nome, farm, sti	eet, factory, office		2	8f. Location (Str. City or Town		r or Rural	Route Numb	per,
ב	itel or irs af ret D ret D led ir	Ce												
	Hospitel or 24 hours afte Funerel Dir tely filled in	edical	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the Examiner: On the b	best of my kn	owledge, deat	n occurred at the til	me, date and	d place, a	and due to the ca	use(s) and man	ner as sta	ited.	
	To the Hospitel or Ai within 24 hours after of To the Funerel Direct completely filled in by	Ved	Uney	and man	ner stated.					or ore tille, da	no and pidce, af	id (109 (()	e cause(s)	
	5 th 5 2	Σ	29b. Signature and title of certifies	1 /	1		29c. Licens	and a	77		d. Date signed		lay. Year)	
						- 1	113	00	12	0	3-2	7-	200	6
			30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	Print)	(11.	,	MI	1	71	LAN
			Jenniter	riedir	1991	5601	Verer	ans t	tigi	5 hwan	1/11/1	ers	V. lel	MID
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8	467	legistrar's Sign	ature	A a			0			00	1108
	Licalon	1100	MAK & O	CUUU AMA	AME I		119							

			1 - For State Registrar	State of Mary		artment of H			Reg. No.	160
	Physici		Decedent's Name (First, Middle, Last Marg	aret Elizabe	eth Bisco	e.		2. Date of De Month April	Day Year	3. Time of Death 9:58 p M
p.	/Medic Examir		4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	ith
		e")	St. Mary's Hospi	tal		Leonardt	own		St. Mary	's
100	Funeral Director		212-20-6344	ex 7. Age (Ir	93 Yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da February	th ly, Year) 9. Bi C 2,1913 Mar	thplace (State or Foreign ountry) yland
	land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				10d. Inside City Limits
	e-f sh	ctor	Maryland St. Mar	ry's	Lexing	gton Park				1 ☐ Yes 2 📉 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	s 23s	eral	19382 Hawkins Lan			20653			USA	
36	be filed within 72 hours after death with the Maryland Hygiene. de Hygiene. de other than "natural", or items 23a or 28e-f show other than "natural", or items 23a or 28e-f show event, the Medical Extra free instilled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2√ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes of No o Rican, etc.)	Black, Whi	te, etc.
Ö	2 hou	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business	.ack /Industry
215	within 7 ene. than "n the Med	Completed	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	furing most of wor)	king		
2	filed w Hygier other th	Col	17. Father's Name (First, Middle, Last)		Home	maker	19 Matheric Nep	no /Fime Middle	Own Home	
Maryland 21215-0036	Mental H Mental H arked of	To Be	Jacob Hawkins				Rosie J		, Maioeri Surriame)	
ary	should be and Menta a marked umatic ev	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a			er, City or Town, State,	Zip Code)
Σ	and 2 salth a n 27 is		Sheila Marie Bumpers	The state of the s			e, Lexingt	on Park, l	Maryland 2065	3
Baltimore,	permit. Pages 1 and 2 should be Opp.rument of Health and Menta Importent; if item 27 is marked any injury or other treumatic of <u>pncs</u> .		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	St. James	osition (Name of matory or other place metery		ril 2006 I	20c. Location - City or exington Park	
Balt	Depentit. Depentit Importe any inji		21. Signature of Funeral Service Licen	in Hardin	2	2. Name and Address ttingley-Ga O. Box 270,	s of Facility			
	nysician /Medical Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olicálions that caused the one cause on each line. a Due to (or as a co	ardiac	er the mode of dyin	uch as cardiac	or respiratory a	rrest,	Approximate Interval Between Or set sid D, ath
8760,	sate be executed hysician and the burial-transit	licai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nse uence of):	entesta	ral he	men	hage	Lay
.O. Box 6	Attending Physician: The law requires that the death certificate be executed to death. The fact is refeath. sclor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P	quires than a signed to a lid be det	by	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the u	nderlying cause give	n in Part I.		obacco use contribute t Yes 2∰No 3∏P	o the cause of death?
Records,	ysician: The law requir is certificate has been si director, page 2 should	Completed	Acu	to Ken	al Fa	lure	-		osy prior to death?	utopsy findings available completion of cause of
ita	sian: artifica ctor. p	Be C	25. Was case referred to medical examiner?				26. Place of Dea			20140
Division of Vital	To the Hospitel or Attending Physis within 2 Hours after death. To the Funerel Director: After this α completely filled in by the funeral dire	ဥ	1 Yes 2 No 27. Manner of Death 1 No Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time o Injury	28c. Injury Work	4 Indising H		dence 6 Other (Spenow injury occurred	cify)
DİVİ	tei or Att rs after de el Directo ed in by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str pecify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
	To the Hospitei or Attendir within 24 hours after death. To the Funerel Director: Al completely filled in by the fu	ledicai	(Check only 2 Medical Exam	ysician: To the best of m niner: On the basis of exa and manner stated.	y knowledge, deatl imination and/or in	vestigation, in my op	inion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	s stated. s to the cause(s)
	Neit To Po	Σ	29b. Signature and title of certifier	1.1	110	29c. License			29d. Date signed (Mon	h, Day, Year)
,	20		rames	1 pros	ALL	D064	19		April 5, 20	006
	73		J. Patrick Jarboe, M.	/ /		Print) d, Hollywood	1 Maryland	20636		
	Sta Registr	te ar	31. Date filed (Monty, Day, Year)			_	ा , ध्या प्रायात	20000		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 17, 2006 **Physician** 8:14AMM S. Barnes Norris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles LaPlata Civista Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days, Year) Aug. 7,1932 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Maryland 73 Director 214-30-1477 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic evant. Its Medical Examinar must be notified at Charles Waldorf MD 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20601 1520 Nicholas Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐ Yes 2 No f Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Itam 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Metro Transit Foreman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filinent of Health and Mental Hitant: If itam 27 is marked out Be Helen Robinson Felix Barnes ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1520 Nicholas Rd, Waldorf, MD 20601 Gloria R. Barnes/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3/25/06 Clinton, Md. permit. Page Department of Important: If any injury or 21. Signature of Funeral Service Licens 22. Name and Address of Facility Adams Funeral Home, PA 20605 Aquasco Rd. Aquasco, MD 20608 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List the ne cause on each line. Approximate Interval Between 2-3 Yrs. Immediate Cause (Final Chronic Renal Falure Physician /Medical resulting in death) Due to (or as a consequence of): Examiner few days Congestive Heart Failure Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, should be Diabetes 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Hypertension page . 1□ Yes 2 No certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Outpatient Other: Medical Certification: To 1 ☐ Yes 2 📆 🕅 o 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred 1 Watural 2 Accident 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the ! 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of/certifier 44436 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patel MD 102 Paul Mellon Ct. Ste 102, Waldorf, MD20602 31. Date filed (Month, Day, Year) State Coach MAR 2 9 2006 Registrar

crn	1_ For		epartment of Health and	Mental Hygien	e e e e e e e e e e e e e e e e e e e
	Registrar		Certificate of Death	Reg. No	(006 11603
Physician	1. Decedent's Name (First, Middle, Last) James Verno	n Butler		2. Date of Death Month Da	
/Medica	4a. Facility Name (If not institution, give sti		4b. City, Town, or Location of Deat	March 27	7 2006 11:29 A ^M
Examiner	38205 Thomas Lane	out and manipoly	Mechanicsville	40	St. Mary's
Funeral	Social Security Number 6. Sex	7. Age (In yrs. last birth	iday) If Under 1 Year If Under 24 Hrs	8. Date of Birth	
Director	215-02-0100	42 Y	rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) OCT • 7, 19	63 Maryland
land	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
Mary of ehe	MD St. Mary	's Mechai	nicsville		1. Yes 2 □ No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: if item 27 is marked other then "naturel", or iteme 23s or 28s-1 ehow ance in jointy or other traumatic event, the Medical Examinar must be notified at ance. To Be Completed by Funeral Director	10e. Street and Number 27655 Mechanicsv	ille Rd.	10f. Zip Code 20659	10g. Cit	tizen of What Country?
deetl	11. Marital Slatus	. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	specify Yes or No-	14. Race - American Indian,
after or its	1 Never Married 2 Married	1 Yes 2 XNo If Yes, Give	1 ☐ Yes 2 🕅 No Specify:	to Hican, etc.)	Black, White, etc. Specify: Black
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ied within 72 hou sign within 72 hou signere. Ner then "nature it the Medical Ent. Completed	15. Decedent's Educa (Specify only highest grade of	completed) (Decedent's Usual Occupation Give kind of work done during most of wo life. DO NOT use retired)	rking 16b. K	ind of Business/Industry
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Page ment o	1 X Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		n of Peace 04/0	03/06 H	elen,Maryland
Balt permit. Depart Import any inj	21. Si natura di Funerat Service Licensee) 191	22. Name and Address of Facility Adams Funeral H	ome, PA 2	0605 Aquasco Rd. o, MD 20608
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only she	tions that caused the death. Do no cause on each line.	t enter the mode of dying, such as cardiac		Approximate the three th
Physician	tmmediate Cause (Final disease or condition	multiple is	nuries		Onset and Death
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Ø ∰ G % Ø	IF FEMALE:				
P.O. BOX hat the death cert d by the attending letached for use a	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Dale of delivery Month Day Year
by the 6 tached tached 1	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)		World Day 16a
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aw requires been sing 2 should be pleted				24a. Was an	24b. Were autopsy findings available
HECOrd The law required to the second to the				autopsy performed? 1 X Yes 2 □ No	prior to completion of cause of death?
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Of V Physic this of all dire	1X Yes 2 No	pitat: 1 Inpatient 2 ER/Outp		ome 5 ☐ Residence	6 Nother (Specify)at scene
On C ding P h. After funera	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Tir	ry Work?	28d. Describe how intur	y occurred weel under truckbed
isio	2 Accident investigation 3 Suicide 6 Could not be	3 -27-Co 11. 28e. Place of Injury - At home, farm	2 2M 1X Yes 2 □ No	20f Lacation (Compt. a.s.	
Division (tal or Attending F rs effer death all Directors this ed in by the funer. Certification:	4 Homicide determined	building, etc. (Specify)	cocal	Gity or Town, State	d Number or Rural Route Number,
Hospi 14 hou 15 Funer Telly fill	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my knowledge, or: On the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	and due to the cause(s)	and manner as stated
To the comple	29b. Signatore and title of certifier	Stated.	29c. License number	29d. Dat	e signed (Month, Day, Year)
	Mat Cho	nice -1200.0	O.C.M.E.		
0	30 Name and address of person who comp	pleted cause of death (Item 23a) (Tr		rar	ch 28, 2006
DBID	PATRICIA ARONG	A. Pollakmo 1	11 Penn Street, Bal	timore, Mary	vland 21201
State Registrar	31. Date filed (Month, Day, Year) MAR 2 9 201	32. Bigistrar's Signature	Loade		-

			1 - For State Registrar	tate of Marylan	d / Depa	artment	of Health a of Death		ntal Hygi		06	1 1 6 0) !
	Physici	an	Decedent's Name (First, Middle, Last)					2.	Date of Death Month	Day	Year	3. Time of D	Death
	/Media			ouise Biddl	e			A	pri1	4	2006	0140	A ^M
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			Union Hospital 5. Social Security Number 6. Sex	7 Ago (/p. 1/5)	la at hinth da	E1k		24 Hrs 0	Data d Di d		ecil		
	Funeral Director		150-40-9393	7. Age (In yrs. 58	Yrs.		Days Hours	Min.	Date of Birth (Month, Day, EPT 13,	Year)	9. Birthpi Coun	ace (State or try)	Foreign
			Usual Residence of Decedent	30				اد	EL 13,	194/	riai	yland	
	nylan how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10	d. Inside City	Limits
	Be-fs	cto	Maryland Cecil	E1:	kton							1 X Yes ∶	2 🗌 No
	∰ 6.24 1.24 1.24	Directo	10e. Street and Number			10f. Zip C			10	g. Citizen	of What Coun	try?	
	ath w	rai	175 Hollingsworth			219					ted Sta		
	er de	Funeral	/	Was Decedent Ever in U. Armed Forces?	.S. 13. \	Was Deceder If Yes, specify	t of Hispanic Orig Cuban, Mexican,	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)		Race - America Black, White, e		
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215-0036	s filed within 72 hours after death with the Maryland I Hygiene. other then "neturel", or Items 23e or 28e-f show vent, I're Medical Expediete over be invilled at		15. Decedent's Education	on .	16a. Deced	dent's Usual (Occupation		1	6b. Kind o	Whi of Business/Ind		
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7	ad wit	Completed	12		Но	memake	r			In H	er Own	Home	
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_	Pages 1 ar nent of Hea int: tf item: iry or other		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Remo		lace of Dispo emetery, cren			priI		West	on - City or Tov Cheste:	r.	
Бащто	t. Pa rtmer rtent:		'4 □Donation 5 □ Other (Specify)	R.A	. Ferris			006	i6.1	Penns	ylvania	a	
מ	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licensee	b) - 0	H	icks H	Address of Facility ome for Stockton	Funera	als, P.	Α.			
		-	23a. Part1. Enter the disease, or complication	ons that caused the death	Do not ente	03 W.	Stockton	_Stree	et, Elk	cton,	Mary1a	ind 219 Approximate	21
12	42.52		shock, or heart failure. List only one ca	use on each line.	50 1101 0111	or the mode c	r dying, spon as c	ardiac or re	spiratory arres	sı,		Interval Betwee	een eath
	Pnysician /Medical		disease or condition resulting in death)	fine up to for as a consequence									
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	cuted nd ransit	Examine	Cause (Disease or injury that initiated events	Cormil	1 Ar	to en	0.80						
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	the a	ysic	1 Yes W No	I□Pregnant at time of de □Unknown	eath 5	Other (speci	fy)				WIOTHIT E	Jay 16	a.i
ŗ.	The law requires that the death the has been signed by the atter rage 2 should be detached for u		Part II. Other significant conditions contribu	iting to death but not resu	alting in the un	derlying caus	se given in Part I.		23e. Did toba	acco use c	ontribute to the	cause of dea	ath?
corus,	w requires that been signed b should be deta	d by				,	9			2 🗆 No		bly 4 ∏Uni	
2	w req	Completed							24a. Was an	24			
ב ב	he la e has ige 2	dmo							autopsy	ed?	b. Were autop prior to com death?	pletion of cau	ise of
		CO	25. Was case referred to medical				00 81		1 ☐ Yes 2)	No	1 ☐ Yes 2	2□ No	
>	ysicien: The lis certificate hadirector, page	OB	examiner? 1 ☐ Yes 2 ☐ No Hospi	tal: 1 X spatient 2 □ 1	ER/Outpatient	t 3□ DOA	Other		heck onlone		Other (Specify)		
5	g Physier this reral direction	n: T	27. Manner of Death	Ba. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?		Describe how				
NISION NISION	ath. ar: Aff	atio	2 Accident investigation	(Monal, Bay (Bar)	Injury	М	1 ☐ Yes 2 ☐ N	lo !					
<u> </u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	Be. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, or	fice	28f.	Location (Stre City or Town,	et and Nu. State)	mber or Rural	Route Numbe	<u></u> ₹Γ,
2	itelo rs aft rel Di led in	Cer						- 1					
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Physicial (Check only one) 1 Medical Examiner:	On the basis of examinat	wledge, death ion and/or inv	occurred at trestigation, in	he time, date and my opinion, death	place, and occurred a	due to the cau It the time, dat	rse(s) and e and plac	manner as sta	ted. he cause(s)	
	o the ithin ; o the omple	Med	29b. Signature and title of certifier	and manner stated.			cense number				ned (Month, D		
	+ ≥ F 8		I Am dec ids	MD			4823		250	41	Lilol	-y, , oai/	
			30. Name and address of person who comple		23a) (Type 1		(00)			1	. 100		
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	Sta	te		32. Registrar's Signat	ture	AND IS	71000		- 11 16	/	1	- 1	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 9, Day 2006 Year **Physician** MARGARET MAE BOYER 3:15 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. CATHERINE'S NURSING CTR. **EMMITSBURG** FREDERICK | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAY 10,1903 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 102 Director MARYLAND 216-48-6817 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director MD FREDERICK **EMMITSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 W. MAIN ST. 21727 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Importent: if item 27 is marked other than *natt
any injury or other treumatic event, the Madical
once. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME 7 HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARVEY В. GRACE KEILHOLTZ OGLE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9904 ROCKY RIDGE RD., EMILY R. SIXX/NIECE ROCKY RIDGE, MD. 21778 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State PLEASANT HILL CEMT. 4/13/06 * 4 □Donation 5 □ Other (Specify) YELLOW SPRINGS, MD. 21. Signatury of Funjeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 23a. Parri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, phock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final dise in e or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2XNo P.0. be detached the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ρ 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No ospitel or Attending Physicien: hours after death. unerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; Injury 1 X Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide To the Hospitel within 24 hours a To the Funerel I Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the time. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and granner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of APRIL 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 310 S. SETON AVE. ALAN CARROLL, M.D., EMMITSBURG, MD. 21727 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 1 2 2006 Registrar

			1 - For State Registrar	State of Ma	aryland		artmen tificate			ind M	lental Hy	/gieņe		1 1 6 0	6
ı	Physici	an	Decedent's Name (First, Middle, Lass JOYCE G. CAPLA)	,							2. Date of D		^y 2006 ^{Yea}	3. Time of Dea 1:50 P	
	/Medie Examir		4a. Facility Name (If not institution, give 11604 HITCHING PO	street and number)			4b. City,		Location of		1211(011	40	County of De	ath	
	Funeral Director		5. Social Security Number 6. S 579-46-3570 1 Usual Residence of Decedent	ex 7. Ag □ M 2X F	e (In yrs. Ia: 68	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D 10/12/	rth ay, Year) 1937	9. B	irthplace (State or For Country) DC	reign
	Maryland a-f show	tor	10a. State 10b. County MD MONTGOM	ERY		Town or Lo								10d. Inside City Lin	-
	th with the 23a or 28a	Funeral Director	10e. Street and Number 11604 HITCHING POS	ST LANE			10f. Zip	Code 0852				10g. Cit	izen of What (Country?	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show amy righty or other traumatic avant, the Medical Exercities must be multiled at once.	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2√ N If Yes, Give Year or Dates:		f	Vas Deced f Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or N Rican, etc.)	0-	14. Race - An Black, Wh Specify:		
Maryland 21215-0036	within 72 hi iene. than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5 2			lent's Usua kind of wor DO NOT us EMAKE	k done d e retired)	tion uring most	of workin	ng		ind of Busines N HOME	s/Industry	
yland	should be filed and Mental Hyg s markad othar umatic avant,	To Be C	17. Father's Name (First, Middle, Last) ALBERT GOLDSMITH							's Name PAT	(First, Middle				
e, Mar	1 and 2 sho Health and am 27 Is m thar traum		19a. Informant's Name/Relationship (7 DONALD CAPLAN (HUS			11604	HITC	HING	POST	LAN	E ROC	KVIL	r Town, State, LE, MD	20852	
Baltimore,	rt. Pages rument of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Euneral Service Licen)	JUDI GARI	ce of Dispos netery, crem EAN ME DENS	EMORIA	her place AL	03		2006	OL	NEY, MI)	
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	Physician /Medical Examiner		snock, or meart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. METASTA Due to (or as	ne. TIC L	UNG CA					- Cospilatory 2			Interval Between Onset and Death	n
,8760,	cate be executed physician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a d											
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rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions co	ntributing to death bu	ıt not resulti	ng in the un	derlying ca	use give	n in Part I.					to the cause of death?	
Vital Records,	The law ate has b page 2 sl	Completed								_			24b. Were a prior to death?	utopsy findings availa completion of cause s 2 \(\text{No} \)	able of
V	Physician: The this certificate ral director, pag	Be c	25. Was case referred to medical examiner?	Hospital:				04-			(Check only o				
Division of	nding Phys ath. r: After this e funeral di	ation: To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 2EF Year) 28	Outpatient Sb. Time of Injury		c. Injury Work	I 4 U I 3	2	le 5 🛛 Resi		Other (Spe y occurred	ecify)	
DIVIS	To tha Hospital or Attanding P Within 24 hours after death. To tha Funaral Diractor: After t completely filled in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	. (Specify)						City or To	vn, State,)	lural Route Number,	
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	To To COL	Σ	29b. Signature and title of certifies	aam				License					e signed (Mon		
	5		30. Name and address of person who c	ompleted cause of de	eath (Item 2)	3a) (Type, P		2330	10		N	1ARCI	1 27, 2	006	
			DR. VICTOR M. PRIE 31. Date filed (Month, Day, Year)				R, SU	JITE	4100,	BET	THESDA,	MAF	RYLAND	20817	
	Sta Registra	-	MAR 2 9 2	32. Registra		An An	and s								

			1 - For State Registrer	State of Marylan			t of He		Mental H	ygiene Regina	006	11607
بالإي	Physici /Medi		1. Decedent's Name (First, Middle, La Annie B. Co	11ette					2. Date of D Month March		^y 2006 ^{Year}	3. Time of Death 12:59 PM
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	Funeral Director		5. Social Security Number 6. S 577–10–8707	Sex 7. Age (In yrs. I	_	If Under Months		f Under 24 Hr Hours Min		Birth Day, Year	9. Birth	place (State or Foreign Intro) 111e, NC
	ryland how		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation						10d. Inside City Limits
	the Ma	Director	10e. Street and Number	Was	shingto							1 ∀Yes 2 No
	th with 23a or	ai Dir	1321 Talbert Ter	race SE		10f. Zip	0020			-	tizen of What Cou nited St	,
9036	d within 72 hours after death with the Maryland Jiene r than "naturel", or fams 23a or 28a-f ehow The Medical Evar, a arrivist be rotified at	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates:	11	Vas Deced Yes, spec	STY Cuban, I	anic Origin? (Mexican, Pue Specify:	Specify Yes or Ninto Rican, etc.)	10-	14. Race - Ameri Black, White Specify: Bla	, etc.
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Maryland 2	permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if item 27 is marked other any fujury or other traumatic event, Induse.	To Be C	17. Father's Name (First, Middle, Last, Rudolph Burgin)			18		ame (First, Middl obinson			21191 00 1119
	1 and 2 sho Health and Hem 27 Is my		19a. Informant's Name/Relationship (Samuel T. Collett	te Jr. (Son)	19b. Mailin 11409	g Address Kett	(Street and tering	Number or F Terra	Rural Route Num ace Uppe	ber, City o r Ma	r Town, State, Zi rlboro,	o Code) MD 20774
Baltimore,	Pages 1 ament of Herant: if item		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	lace of Disposemetery, crem	atory or of	ther place)	em. 4,	Date /4/06		ocation - City or Titland,	•
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£	Physician		23a. Part1. Enter the disease, or com shock, or heed failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that daused the death one cause on each line.	. Do not ente	or the mode	e of dying, s	such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
68760,	Medical Examiner bhysicien and sthe burial-transit	edical Examiner	Sequentially list on ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	lence of):			<i>J</i>				
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<u> </u>	ysician s certif directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatient	3∏ DO/	0.1		ath (Check only		6 □Other (Specif	
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	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai (29a. Certifier (Check only one) Certifying Ph 2 ☐ Medical Exam	ysicien: To the best of my know niner: On the basis of examination and manner stated.	vledge, death on and/or inve	occurred a estigation,	at the time, o	date and plac on, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as s place, and due to	tated. o the cause(s)
)	Tot withi Totl comp	- Appendix	29b. Signature and title of certifier	Shah,		29c.	License nu	1706	6		e signed (Month,	
	10		30. Name and address of person who a			,					,	-
零	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ure de	ade	Leon	at a tow		050		

■ Cox, Clarence ■ Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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F (46)	vo Sh	Decedent's Name (First, Middle, Last)					2. Date of Death	1	3. Time of Death		
Physic		Clarence Lewis Cox						April	5 2006		
/Med		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4c. County of D		
Exami	ner	Union Hospital Elkton							Cecil		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)							Birth 9. Birthplace (State or Foreign Country)		
Director		218-70-3448	M 2□F 47	7	Yrs.	Months Days	Hours Min.	April 18,	1958 N	Maryland	
D		Usual Residence of Decedent									
nylan how		10a. State 10b. County		10c. City, T	Fown or Lo	cation				10d. Inside City Limits	
e Ma	cto	Maryland Cecil		E1	kton					1 ☐ Yes 2 📉 No	
ours after deeth with the Marylan el', or iteme 23a or 28a-f ehow Examinar must be myttlied at	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?	
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r dee	Funeral	TT. Wallar Claras	Was Decedent E Armed Forces?		13. V	Vas Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		merican Indian, /hite, etc.	
or in	by Fu	1 Never Married 2 Married 1 Yes 2 No			1 ☐ Yes 2 X No Specify:				Specify:		
urel'		3 Widowed 4 Divorced Year or Dates:				Decedent's Usual Occupation			Black 16b. Kind of Business/Industry		
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withii ane.	Ę	Elementary/Secondary (0-12) College (1-4or 5+)			Assembler				Manufacturing		
filed within 72 hours after deeth with the Maryland Hygiene. Hygiene. ther then "naturel", or iteme 23a or 28a-1 ehow out, the Madical Examiner must to nytitled at		17. Father's Name (First, Middle, Last)			1100	CIIIDICI	18. Mother's Nar	me (First, Middle, M		0	
d be antal	Be C	Clarence Oscar Cox					Sally M. Early				
inoul ad Me mark	70					ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Co			e, Zip Code)		
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "nature any injury or other traumatic event, the Madical occurs.	1	Sally M. Cox/Mothe		1	143 K	irk Road	l. Elkton	, Maryland	1 21921		
Hea Hea	1	20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of		Date 2	t0c. Location · City	or Town, State	
Pages nent of I unt: If it		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Grif	fith	A.U.M.P	* Apr 200	il 10,	odar Hil	1, Maryland	
artme		21. Signature of Funeral Service Licenses	1	Chur	rch Ge	metery Name and Add				·	
Depared Important	И	21. Sign sture of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921									
Se #		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate									
* 1		shock, or heart failure. List only one Immediate Cause (Final			10000	. 21	15 14 1			Interval Between Onset and Death	
Physician /Medical	_	disease or condition resulting in death)				UHL 11	FXICTIO				
Examiner		Due to (or as a consequence of): DIABGTES WELLITUS							1 662		
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		equence of):					10-16-1		
uted d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	- Hy	•			1 YBM				
be executed sician and burial-transit	Exa	resulting in death) Last	nce of):								
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The law requires that the death certificate are bas been signed by the attending physpage 2 should be detached for use as the	Physician/Medi					· · · · · · · · · · · · · · · · · · ·			1		
th cer endir r use	an/A	1F FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death				lEctopic pregnan	cv		23d. Date of		
deal deal de fo	SICIS	in the past 12 months? 1 ☐ Yes 2 ☐ No	Other (specify)			Month Day Year					
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requir been s	ted							1 Yes	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💥 Ur		
e law r has be	Completed							24a. Was an autopsy	/ prior	autopsy findings available to completion of cause of	
The laste has page	No						ped 1 ☐ Yes		ned? death? 2√No 1 □ Yes 2/No		
sian: srtific ctor.	Be (25. Was case referred to medical 26. Place of Death (Check only one)									
hysic his ca	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 X ER/Outp									
ng P	on:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year) 28	28b. Time of Injury at Work?			28d. Describe how injury occurred			
eath.	catl	2 Accident investigation			M 1 Yes 2 No						
or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)				, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
urs a	O										
Host 14 ho Fund fely fi	edical	29a. Certiflier (Check only (C									
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. D						d. Date signed (M	lonth, Day, Year)		
F 3 5 8		I Antonish by mal									
^									4-7-06		
b		30. Name and address of person who cor					<u>.</u> π11 ⋅	М. 1	1 01001		
THE STATE OF	tate	Rolando A. Najera, 31. Date filed (Month, Day, Year)	11. D. 1. 32. € gistra	oo Cat ar's Signatur	nedra	Stree	t, Elkton	, Marylan	a 21921		
Regis		31. Date filed (Month, Day, Year) APR 1 3 20	06	as A	1	and I					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Velma Spence Campbell 2006 РМ April 2118 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurelwood Care Center E1kton Ceci1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, July 30 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F Director Yrs 216-38-3146 88 Pennsylvania 1917 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itams 23a or 28a-f ahow traumatic event, the Medical Examinar musicke notified at 10d. Inside City Limits Director 1 Yes 2 □ No Ceci1 Maryland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Colonial Manor Court 21921 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygione. and the shar shar is the shar is marked other than "natural; or Ital ury or othar traumatic event, the Medical Earn is ury or othar traumatic event, the Medical Earn is any 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ 3 ₩ Widowed 4 Divorced Specify White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Her Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Ellis Spence Martha Mathilda Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth G. Campbell/Son 461 Revere Terrace, Fremont, California 94539 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place)
Cherry Hill
Methodist Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) April 8, permit. Page Department of Important: If any injury or once. Cherry Hill, Maryland 22. Name and Address of Facility. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DRP10M10PATH SCHEMIC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CINF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 21 No 25. Was case referred to medical 26. Place of Death (Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: / 2 Accident investig uon 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Gentrying Physician: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) Im erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 817 CHURCHMANS CTR NEW CASTLE DE State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amended 20b, 3/30/06, LDB, DOR Certificate of Death Reg No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 16REMIAI /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death ## Hours | Min. | S. Date of Birth | Month, Day, | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Min. | Examiner Sykesville Careat ontinuum Birthplace (State or Foreign Country) 5. Social Security Number 6. Şex 1 M 2 ☐ F 7. Age (In yrs. last birthday, **Funeral** a Baha 267072446 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show event, the Medical Examiner must be notified at 1XYes 2 □ No ambridge Dorchester Directo Maryland 10e. Street and Number 10g. Citizen of What Country? Of. Zip Code SA 21613 109 Washing by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Afro Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced neture!', Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) minister Religion None (06) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other eny injury or other treumatic event QDCB. Rebecco G. Richardson Jeremiah Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1390 Harlow Dr. Pittsburgh PA 15204 Ruth C. Lewis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 1 1 8 Burial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cementry Cambridge * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility gla Hubbardst. Cambridge, m.D.21613 nattie Boardley Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 181m **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 20 M and Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Tyes 2 1 NO To Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ Mo 4 Narsing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\tag{Homicide} 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 1/200

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

Robert B. Kroopnick, M.D

29d. Date signed (Month, Day, Year)

			For State of Maryla	nd / Department of Health and M Certificate of Death	lental Hygie	211116 1 1 6 1 1
3	Physici	an	1. Decedent's Name (First, Middle, Last) Helen E. Collins		2. Date of Death Month	Day 7 2006 1429 M
	/Medio Examir	_	4a. Facility Name (If not institution, give street and number) Memorial Hospital at E	Easton Easton	1.160 0.1	4c. County of Death Talbot
- <u> </u>	Funeral Director		5. Social Security Number 217-86-3705 6. Sex 1 □ M 2 ▼ 7. Age (In yrs	s. /ast birthday) 7 8 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Mar. 29,	ear) 9. Birthplace (State or Foreign Country) 1927 Maryland
	the Maryland 28a-f show	ctor		City, Town or Location Easton		10d. Inside City Limits 1 ☐ Yes 2 ∑ No
	with the	Direc	10e. Street and Number	10f. Zip Code		Citizen of What Country?
len 36	s after death with the Maryland , or Itema 23a or 28a-f show entitled at	by Funeral Director	28392 Villa Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 3 ☑ No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: White
Hele 1215-0036	within 72 hours iene. 'then "natural', '	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)	ng	. Kind of Business/Industry
_o / / i n s, Maryland 21	filled Hygi other	To Be Col	11 17. Father's Name (First, Middle, Last) Huey J. Ershine	Homemaker 18. Mother's Name Sally K:	e (First, Middle, Maid	
, o / Mary	12 should be h and Mental 7 Is marked of Iraumatic sv		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rura		
ig(Baltimore, I	Pages 1 and 2 bent of Health nt: If Item 27 Iny or other tre		1 Burial 2 Coremation 3 Bemoval from State	Place of Disposition (Name of cametery, cramatory or other place)	Date 20c	Location - City or Town, State aston, Maryland
Balti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee Multiple 7 - Eshaw	22. Name and Address of Facility Fra 216 N. Main St., Fe	amptom F ederalsbu	uneral Home, P.A. rg, MD 21632
8760,	The law requires that the death certificate be executed We directly the attending physicien and the burial-transit to be detached for use as the burial-transit.	dicai Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequent Father to the conditions).	Chronic Obstructive F equence of): ilation with rapid vent equence of): od pressure equence of):	Pulmonar	Interval Between Onset and Death Onset and Dea
P.O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
rds, P.	w requires that the been signed by should be detact		Part II. Other significant conditions contributing to death but not re Uncontrolled diabetes	sulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
al Reco		Completed by			24a. Was an autopsy performed 1 Yes 2 2	
f Vita	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2 [Othor	n <i>Check only one</i> me 5 ☐ Residence	e 6 ⊡Other (Specify)
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: 7	27. Manner of Death 1 Vatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28d. Describe how in	njury occurred t and Number or Rural Route Number.
Divi	tal or Al	Certif	4 Homicide determined 25e. Place of Injury - At building, etc. (Special Control of the Control o		City or Town, Si	tate)
	the Hospi hin 24 hour the Funer mpletely fill	Medical	29a. Certifier (Check only one) 1 ✓ Certifying Physician: To the best of my king the part of examiner: On the basis of examiner and manner stated.	nowledge, death occurred at the time, date and place, anation and/or investigation, in my opinion, death occurred	ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
	Will P O		30. Name and address of person who completed cause of death (little	D. 6336	0 3/	28/06
			Schail Aman 215		Federa	alsburg, mD
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 3 2006 32. Registrar's Sign	nature (

			For State Registrar	State o	f Maryland		artment of H			ene 0 0 (5 11612
n	· · · · · · · · · · · · · · · · · · ·	A	Decedent's Name (First, Middle	e, Last)					2. Date of Death	1	3. Time of Death
	Physici /Medic		CHARLES WILLIA	M DUDLEY					Month MARCH	'	06 2:08P M
1	Examin		4a. Facility Name (If not institution		mber)		4b. City, Town, or	Location of Death		4c. County of	
			SOUTHERN MARYL	AND HOSPI	TAL		CL	INTON		PRIN	CE GEORGES
1	Funeral		5. Social Security Number	6. Sex XX M 2□ F	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director		193 03 6639	NAM 2UF	9.0	Yrs.			APR. 12,	1915 N	ORTH CAROLINA
	and *		Usual Residence of Decedent 10a. State 10b. County		10c, City.	Town or Lo	cation				10d. Inside City Limits
	Aaryil Feho	5		E CEODGEG							XXYes 2 □ No
	28a-	ect	MD PRINC 10e. Street and Number	E GEORGES	FUR	ESTVII	10f. Zip Code		10	g. Citizen of Wh	at Country?
	with Ba or	Funeral Director		TEDD A CE				207/7			
	heath	era	5236 DAVENTRY 11. Marital Status		edent Ever in U.S	. 13. \	Was Decedent of His	20747 spanic Origin? (St	ecify Yes or No-	UNITED	American Indian,
(0	r Her	Fun	1 ☐ Never Married 2 ☐ Marri	Armed Fo		7/43-	f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		White, etc.
9	al', o	by	X3√ Widowed 4 Divorced	ÎÎ Yes, Gir Year or D	ve 12/2	0/45	1 ☐ Yes XXX No	Specify:		Specify:	BLACK
21215-0036	72 hours after death with the Maryland natural', or iteme 23a or 28e-f ehow deat Exeminet must be motified at	Completed by	15. Deceden	t's Education st grade completed)		16a. Deced	dent's Usual Occupa kind of work done d	tion	cino.	6b. Kind of Busin	ness/Industry
2	within ene. then "	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired)		ang .		
	filed w Hygier other th	Cor	5TH			MAI	NTENANCE			VA HOS	
pu	be fill	Be	17. Father's Name (First, Middle,	Last)					e (First, Middle, M	laiden Sumame)	
y la	should ind Men marke umatic	To	NORMAN DUDLEY					NANNY 1			
Maryland	C/ ca - ca		19a. Informant's Name/Relations		A II CII MII D		ng Address (Street a				
	1 and Health em 27		CHARLENE N. BA 20a, Method of Disposition	RNARD / DA	AUGHTER 20b. Pla		DAVENTRY sition (Name of				MD 20747 ty or Town, State
Ď	nt of nr or or or or or	1	XX Burial 2 Cremation		State	netery, cren	natory or other place)			
Baltimore,	it. Partiment		4 ☐ Donation 5 ☐ Other (S 21. Signature of Fune(al Service		LONG		ND NAT. C		3/2006_	LONG IS	SLAND, NY
Ba	permit. Pages 1 and Department of Heall Important: if Item 2 eny injury or other ance.		P	L.	0 0	M.A	ARSHALL'S	FUNERAL			
			23a. Part Enter the disease, or	complications that of	aused the death.		308 SUITLA			ND, MD	Z0/46 Approximate
	Ca. X		shoot, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.	12			. ,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Di	(or as a conseque	W My	1 pally				
	Examiner			1	(OI as a conseque	Head	there .				
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due o	(or as a conseque	nce of):	1 Offerto				
	outed nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S .							
o,	en ar irial-ti	EX	resulting in death) Last	Due to	(or as a conseque	nce ol):					
68760,	ficate be executed physicien and s the burial-transit	dlcal		d							
_	ing pl		IF FEMALE:								-157
30	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	1☐Live b	tcome of pregnand birth 2 🗆 Fetal d	eath 3	Ectopic pregnancy			23d. Date of Month	,
P.O. Box	Physician: The law requires that the death certif this certificete hes been signed by the attending ral director, page 2 should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregn 9☐Unkno	nant at time of dea own	th 5 □	Other (specify)			Worter	Day real
	hat the deby detac	F.	Part II. Other significant condition	ns contributing to de	eath but not result	ing in the ur	derlying cause awa	n in Part I	23e Did tob	coo usa contribu	ute to the cause of death?
ds,	signed be del	d b	Carcinomy Prost				identyling eddade give.	THIT WILL.	1 ☐ Yes		□ Probably 4 □Unknown
Ö	w requir been si should I	etec									
3eC	hes hes	Completed							24a. Was an autopsy perform	prio	re autopsy findings available or to completion of cause of ath?
a	n: Th								1 ☐ Yes 2	1 □	Yes 2⊠No
₹	sician certif recto	Be	25. Was case referred to medical examiner?	Hospital:	/		Othe		h (Check only one		
ō	Phys raldi	5	1 Yes 2 No 27. Manne≰ of Death	28a. Date		R/Outpatient 8b. Time of	3 DOA	4 Nursing Fig	me 5 Resider		(Specify)
on	ding h. Afte fune	tlon	1 Natural 5 Pendin	g (Mon	th, Day Year)	Injury	28c. Injury Work M 1 □ Y	es 2 □No	200. 2000. 20 110	· injury occurred	
Division of Vital Records,	after death. Director: A	fica	3 ☐ Suicide 6 ☐ Could	not be 280 Blace	ol Injury - At hom	e, larm, stre			28f. Location (Stre	et and Number	or Rural Route Number,
á	after after i Dire	Certification:	4 Homicide	buildi	ng, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)	
	pspita hours inera y fille		29a. Certifier 1 Certifyir	g Physician: To the	best of my knowl	edge, death	occurred at the time	e, date and place,	and due to the car	use(s) and mann	er as stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical	(Check only 2 Medical one)	Examiner: On the ba	asis of examinatio ner stated.	n and/or inv	estigation, in my op	inion, death occur	red at the time, dat	te and place, and	d due to the cause(s)
	To t To tl	Ň	29b. Signature and Itle of certifie	. 1			29c. License	number	29	d. Date signed (A	Month, Day, Year)
(AMA		Nam	(in)			D000	55120	12	Turch 2	8 2006
	Ur I AA		30. Name and address of person		se of death (Item 2	3a) (Type, I	Print)	000 1	210 1	/ ,	DC 20032
	D		Kichand Palma		328 Sout	rem	avenue -	se smite	SIO WE	hington	UC 20032
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signatu	H 2:					

		•	, Fot	artment of Health and Mental Hy	giene	3
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Do Month	aath 3. Time of De	ath M
	/Medic	_	James Craig Downing 4a. Facility Name (If not institution, give street and number)	March 4b. City, Town, or Location of Death	27, 2006 10:59 A	1
	LXaiiiii	ICI	100-B Acton Lane	Waldorf	Charles	
	Funeral		5. Social Security Number 6. Sex 1 Am 2 F 7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. (Month, D	ay, Year) Country)	o <i>reig</i> n
	Director		Usual Residence of Decedent		7, 1960 Washington D	
	ehow	'n	10a. State 10b. County 10c. City, Town or Lo		10d. Inside City L 1 ☐ Yes 2	
	the N	rect	Maryland Charles Waldor 10e. Street and Number	T 10f. Zip Code	10g. Citizen of What Country?	
	th with	al Di	100-B Acton Lane	20602	US	
	tems	uner		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.	
336	urs afte	Completed by Funeral Directo	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☒ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: White	
2 2	72 hou	eted	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry	
121	within ane. then "	mp	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Mechanic	Automotive	
d 2	illed Hygie other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle		
ylar	Menta Menta arked atic ev	To B	John W. Downing, Sr.	Linda Faye Pr		
Mar	d 2 sh th and th sm 7 is m traum			ng Address <i>(Street and Number or Rural Route Numb</i> Marvin Drive, Indian Hea		
ē,	s 1 an f Heal item 2 other		20a. Method of Disposition 20b. Place of Dispo		20c. Location - City or Town, State	
<u><u>E</u></u>	Page ment o ant: If ury or		4 Donation 5 Other (Specify)	ematory 3-29-06	Waldorf, MD	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: if item 27 is marked other then "natural", or items 23s or 28s-1 show eny injury or other traumatic event, the Mudcal Enantral master matter and once.			2. Name and Address of Facility 3035 (untt Funeral Home POB 1	Old Washington Road 56, Waldorf, MD 2060)4
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent- shock, or heart failure. List only one cause on each line.		arrest, Approximate Interval Betwee Onset and Dea	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ARTERY DISINGE.		
	Examiner		HYPEZTEN	410N		
	Sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	execute and al-tran	Examiner	resulting in death) Last C			
8760,	icate be executed physician and s the burial-transit	icai E	d			
	ertifica ing ph e as th		IF FEMALE:			
Box 6	eath certific attending p I for use as I	Physician/Med	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Yea	ır
Р. О.	by the de	hysic	1 Yes 2 No 9 Unknown			
	gned be de	þ	Part II. Other significant conditions contributing to death but not resulting in the un		tobacco use contribute to the cause of deat	
Records,	w requir been si should	Completed		24a. Wa	Yes 2 No 3 Probably 4 Unki	
æ	he lav e has age 2	dwo		auto		e of
ital	ding Physician: The I h. After this certificate he funeral director, page	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check only		-
≥	Physic this co	၉	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manger of Death 28a. Date of Injury 28b. Time of		idence 6 Other (Specify)	
CO	ding After fune	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	f 28c. Injury at 28d. Describe Work? M 1 □ Yes 2 □ No	now injury occurred	
Division of Vital	f or Atter after dea Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		(Street and Number or Rural Route Number wn, State)	r,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to the vestigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. , date and place, and due to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of partition	29c. License number	29d. Date signed (Month, Day, Year)	
			• (0)	D42509	3/27/06	
/	BBIA		30. Name and address of person who completed cause of death (Item 23a) (Type, Meindart Smith, 12070 Old Line Cente		D 20602	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2006 32. Repetrar's Signature			
		_	HIALL O O ZOOD	<i></i>		

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Female: 23d. Date of delivery 23d. Date of deliv			ı	1 - For State Registrar	State of Mar			of Health an <i>of Death</i>	d Mental Hy	ygiene Reg. No.	006	11615
Figure 19 1 The property of th				Decedent's Name (First, Middle, Last	1)							3. Time of Death
## Courty of Death Shady Grove Adventists Hospital ## Courty of Death Shady Grove Adventists Hospital ## Courty of Death Shady Grove Adventists Hospital ## Courty of Death Shady Grove Adventists Hospital ## Courty of Death Shady Grove Adventists Hospital ## Courty of Death Shady Grove Adventists Hospital ## Courty of Death Shady Grove Adventists Hospital ## Courty of Death Shady Grove Adventists Hospital ## Courty of Death Shady Grove Adventists ## Courty of Death ## Courty				Lisa Dennison								6:10 a M
Signature Sign						oital			Death		•	y
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The control of the	ŏ ?	z no	ted			16a. Dec	edent's Usual (occupation	Lucation	16b. Kin	d of Business/In	dustry
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Blanck 22 Commands of Specify Metropolitan Crematory 2006 Alexandria, Virginia Complete Command Comm	Ma,	and 2 st alth and 127 is r								. ,		/
Solid University Blvd, W, Silver Spring, MD 2090 Soli	more	ent of He nt: If Item ry or oth	,	1 ☐ Burial 2 ☑ Cremation 3 ☐ F		cemetery, cri	ematory or other	r place) Ma	rch 28,			
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Physician (Medical Examiner) Part Physician (Medical Examiner) Physician (Medical Examiner) Part Physician (Medical Examiner) Physician (Medical Examiner				23a. Part1. Enter the disease, or comp	lications that caused th	death. Do not e	nter the mode of	f dying, such as car	diac or respiratory	arrest,		
Due to (or as a consequence of): Due to	P	hysician		Immediate Cause (Final							1	Onset and Death
Sequentially list conditions Sequentially list conditions Sequentially list conditions		/Medical			u		cancer					
The standard of the standard o	E	xaminer		Sequentially list conditions	b							
The standard of the standard o	7	2 #	iner	any, leading to im rediate cause. Enter Underlying	Oue to (or as a r	consequence of):						
Section Sect	9	and -trans	Kam	that initiated events	C. Due to for as a	consequence of):						
Female: 23d. Date of delivery 23d. Date of deliv	60,	icien			500 to (0) d3 a c	sonsequence or).						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	587	phys s the	adic		d							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	X	nding use a								23	3d. Date of delive	erv
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	Ď į	e atte	icia	in the past 12 months?	4 Pregnant at tin						Month	Day Year
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25. Was case referred to medical axaminer? 1		n signed uld be de	þ	Part II. Other significant conditions co	intributing to death but i	not resulting in the	underlying cau	se given in Part I.				
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25. Was case referred to medical examiner? 1	ž ?	ate ha	E						perf	formed?	death?	
29a. Certifier (Cineck only one) 29b. Signature and differ of certifier 29b. Signature and differ of certifier 30. Name and address of person we completed cause of death (Hem 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, MD 20832	ıta	ctor.	0	evaminer?				26. Place of				
29a. Certifier (Check only one) 29b. Signature and differ of certifier 29b. Signature and differ of certifier 30. Name and address of person to completed cause of death (Mem 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, MD 20832	2	v 10	0	1 ☐ Yes 2X No	1 Lanpatient	2 ER/Outpatie		4 1401311	ng Home 5 ☐ Res	sidence 6	□Other (Specif	y)
29a. Certifier (Cineck only one) 29b. Signature and differ of certifier 29b. Signature and differ of certifier 30. Name and address of person we completed cause of death (Hem 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, MD 20832	ou o	fune from	tion:	1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y			Work?	28d. Describe	how injury	occurred	
29a. Certifier (Check only one) 29b. Signature and differ of certifier 29b. Signature and differ of certifier 30. Name and address of person to completed cause of death (Mem 23a) (Type, Print) Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, MD 20832	N S	ter dea lrector	rtifica	3 ☐ Suicide 6 ☐ Could not be	289. Place of Injury	r - At home, farm, s (Specify)	treet, factory, o	ffice			Number or Rura	al Route Number,
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30. Name and address of person to completed cause of death (Nem 23a) (Type, Print) Joseph Kaplan, M.D 18111 Prince Philip Drive, Olney, MD 20832	100	24 ho	dica	Check only 2 Medical Exami	iner: On the basis of 62	xamination and/or i	ith occurred at nvestigation, in	he time, date and p my opinion, death o	lace, and due to the occurred at the time	e cause(s) a , date and p	and manner as si place, and due to	tated. o the cause(s)
30. Name and address of person to completed cause of death (New 23a) (Type, Print) Joseph Kaplan, M.D 18111 Prince Philip Drive, Olney, MD 20832	1	To th	Me	29b. Signature and fitte of certifier								
Joseph Kaplan, M.D 18111 Prince Philip Drive, Olney, MD 20832) LKC	1	\sim		22022		Mal	LCII 2/,	2000
31 Date filed (Month Day Year) 32 Benistrar's Signature												
State 31. Date filed (Month, Day, Year) 32. Hegistrar's signature		12						ive, Olne	ey, MD 20	832		

			1 - For State Registrar	State of M	aryland				lealth a D <i>eath</i>	ınd M	ental Hy	giene	W 0	6	1616
		· 3.	Decedent's Name (First, Middle, L.	ast)							2. Date of De	ath			3. Time of Death
75	Physici		Louis Dyson								Month April	Da	-	Year 2006	10:25 p ^M
	/Medi Examir		4a. Facility Name (If not institution, gr	ve street and number))		4b. City	, Town, or	Location o		Thri	4c		of Death	10:25 р
*	LAGITIII	ici	Solomons Nursin	g Center				Solo	mons				Ca1	vert	
	Funeral				ge (In yrs. I	ast birthday)		r 1 Year	If Under 2		8. Date of Bit	rth			lace (State or Foreign
1	Director		215-54-8297	1 ® M 2□F	76	Yrs.	Months	Days	Hours	Min.	(Month, Da July 2		929		cyland
	D		Usual Residence of Decedent								041) 2		121	1141	Jana
	rylan how		10a. State 10b. County		10c. City	, Town or Lo	cation							11	0d. Inside City Limits
	a-f-a	cto	MD St. Ma	ry's	M	lechan	icsv	ille							1 ☐ Yes 2 No
	or 28	ire	10e. Street and Number				10f. Z	ip Code				10g. Cit	tizen of \	What Coun	itry?
	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f show its Medical Examinat must be notified at	Funeral Director	27559 Gold Lane					2065	9			Un	ited	Stat	es
	dea	iner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Dece	edent of H	ispanic Orig	gin? (Spe	cify Yes or No	D-		e - Americ	
9	or It	/Fu	1 Never Married 2 Marned	1 Tes 2			1 🗆 Yes		Specify:	, , , , , , , , , , , , , , , , , , , ,	,,		Specifi		otc.
8	irel',	d by	3 Widowed 4 Divorced	Year or Dates:		1							Specin		lack
21215-0036	72 h	Completed	15. Decedent's I (Specify only highest g	ducation rade completed)		16a. Dece (Give	kind of w	ork doné d	during most	of workii	ng	16b. K	ind of B	usiness/Inc	dustry
12	hen.	lg m	Elementary/Secondary (0-12)	College (1-4or	5+)			use retired	"						
2	Hygien Hygien Sther t		9		1	F	armei	:	40.14-45-	d. M	(P**			<u>ultur</u>	·e
ī	be fi	Be	17. Father's Name (First, Middle, Las	1)							(First, Middle			10)	
yla	should be and Mental I is marked or umatic eve	2	Elwood Dyson							-	hine Ca				
Maryland	2 sho s and ls ma rauma		19a. Informant's Name/Relationship				-				Route Numb				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f ehow empty righty or other treumatic event, the Medical Examinations to purifyed as once.		Barbara Dyson/Ni		not Di	Andrew Control of the Control			TA SE		, Balt:	_			
Baltimore,	ges 1 I of F If ite or ot		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	1 00	ace of Dispo emetery, crei	natory or	other plac	e)	U	ate	20c. Lo	ocation -	City or To	wn, State
Ë	men men tant:		4 Donation 5 Other (Spec	(h)	Que	en of					2006			Mary	
Sall	Departition Depart		21. Signature of Funeral Service Cic	See											ne, P.A.
ш	20229		Edward N. Brinsf	ield, Jr.	M000	52	22955	Ho1	1ywood	d Ro	ad, Lec	marc	ltow	п, Мр	20650
8760,	Physician Medical Examiner Medical Examiner Physician and physician and the pruisi-transit Physician Phy	dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as		ience of):									
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[⊡Ectopic p ⊡Other (s	oregnancy						te of delive	ry Day Year
	quires the n signed ald be de	by	Part II Other significant conditions Diabetes	contributing to death t	out not resu	liting in the u	nderlying	cause give	en in Part I.			obacco u Yes 2		ribute to th	e cause of death? ably 4 Unknown
00	w require s been signature should b	Completed									24a. Was	an	24b. \	Were autor	osy findings available
Re	The lav	Ĕ										psy projed?/		prior to con death?	osy findings available npletion of cause of
ā			25. Was case referred to medical	T					00 Plana	-4 Darah	1 Yes	2) No		I □ Yes	₹No
5	s cert rect	o Be	examiner?	Hospital:	ont 2 🗆 I	ER/Outpatier	nt 3 🗆 D	Oth	ar \/		(Check only		e Doth	a. (Cat	
o	Phy r this	1: To	27. Manner of Death	28a. Date of Inju		28b. Time o		28c. Injun Worl			ne 5 Resi				′)
o	ding th. Afte	ţ	1 Natural 5 Pending 2 Accident investigation		y Year)	Injury	М		k? Yes 2∐N			·			
Division of Vital Records,	al or Atter s after dea il Director d in by the	Certification:	3 Suicide 6 Could not determine	De Diago of la	jury - At ho tc. (Specify	me, farm, str	eet, facto	ry, office		2	8f. Location (City or To	Street an wn, State	d Numb	er or Rura	l Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)	hysician: To the best miner: On the basis o and manner st	of examinat	wledge, deat ion and/or in	h occurred vestigatio	d at the tim n, in my op	ne, date and pinion, deat	place, a	nd due to the ad at the time,	cause(s)	and ma	inner as sta and due to	ated. the cause(s)
	To the comp	Σ	29b. Signature and title of certifier				29	c. License	number			29d. Da	te signe	d (Month, L	Day, Year)
	0		> Minter	-				Di	585	72		Apple	il 1	1,20	06
	5		30. Name and address of person who	completed cause of	death (Item	23a) (Type,	Print)		-01			1		,,,,,,,	- P
1	2		Gwyneth A. Bla					ve. F	rince	Fre	derick	, Ma	rv1:	and 20	0678
	Sta	-	31. Date filed (Month, Day, Year)		rar's Signat										7-7-1

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylan	d / Depa		lealth and	F	giene 06	11617
	Dhysisi	an s	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Ye	3. Time of Death
	Physici /Medio		James Jose	ph Dellaquila				April 5		12:50 A M
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, o			4c. County of D	
		: 3	Calvert Memorial			Prince			Calver	
*	Funeral Director		5. Social Security Number 143-12-9464 Usual Residence of Decedent	7. Age (In yrs. I 3 M 2 □ F 87	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	lin. 8. Date of Birtl (Month, Day March 22		Birthplace (State or Foreign Country) w Jersey
	and and		10a. State 10b. County	10c. City	r, Town or Lo	cation				10d. Inside City Limits
	f sh	Į,	Maryland St. Mary'	s Ri	dge					1 ☐ Yes 2 🖁 No
	289	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	3a or	D	49590 Portneys Ove	rlook Road		20680			USA	
	death ms 2	ere		12. Was Decedent Ever in U.	S. 13.		ispanic Origin?	(Specify Yes or No- lerto Rican, etc.)	14. Race · A	merican Indian,
D	or its	Ē	1 Never Married 2 Married	Armed Forces? 1. ∑Yes 2 □ No		1 Yes, sp <i>ec</i> ity Cuba 1 □ Yes 2 X No	Specify:	јепо нісал, етс.)		/hite, etc. White
3	rai', c	i by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		TLI Tes ZALINO	зреспу:		Specify:	WILLE
ה	72 h natu dica	Completed by	15. Decedent's Edu (Specify only highest grad		16a. Deced (Give	dent's Usual Occup kind of work done DO NDT use retired	ation during most of	working	16b. Kind of Busine	ess/Industry
7	han n	μpi	Elementary/Secondary (0-12)	College (1-4or 5+)		s Blower	a)		Class C	-mn a n 17
7	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itama 23a or 28a-f show int, the Medical Examinat must be notified at	ပိ	17. Father's Name (First, Middle, Last)		GIAS	s blower	18 Mother's	Name (First, Middle,	Glass Co	ompany
Maryiana z i z i 3-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itams 23a or 28a-f show amy injury or other traumatic event, the Madical Examinat must be notified at ance.	To Be	John Joseph Della	quila				ry Diprim		
<u> </u>	2 sh and is m		19a. Informant's Name/Relationship (Ty					Rural Route Numbe		e, Zip Code)
	and lealth m 27 her ti		Michele M. Yeatma		A commence of the commence of	and the same of th		Road, Ridge,		Taura Chana
5	Pages 1 nent of H ant: If Ite ury or ot		20a. Method of Disposition 12 ☐ Cremation 3 ☐ F	ternoval from State		sition (Name of matory or other place	I AD	ril 7,	20c. Location - City	
	tant:		4 □ Donation 5 □ Other (Specify)			art Ceme	Lery	2006		, New Jersey
parimore,	Departition Depart		21. Signature of Funeral Service Licens	Herdiner				uneral Home, town, MD 206		
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition	idations that caused the death ne cause on each line.	Do not ent		ig, such as card		rest,	Approximate Interval Between Onset and Death
1,00,	ate be executed with the purial-transit and the purial-transit and the purial-transit are as a second of the purial-transit and the purial-transit are as a second of the purial-transit are a second of the purial-transit are as a second of the purial-transit are a seco	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).						
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ras, r	quires that in signed b	ed by P	Part II. Other significant conditions con Angemy'co, Po	ntributing to death but not resu 2Miphenal V			en in Part I.			e to the cause of death? Probably 4 Tunknown
Heco	The law re te has bee age 2 sho	Completed by	Atheroscienoth	'c Cardio 1	rasce	ucon di	sease	24a. Was a autop perfor	sy prior	
<u> </u>	an: rtifica tor, p	0	25. Was case referred to medical				26. Place of I	Death Check only or		163 20110
>	ysici is ce direc	To B	examiner?	lospital: 1 Inpatient 2 🗆	ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursin	g Home 5 Resid	ence 6 Other (5	Specify)
0 00	ding Pt. th. : After the function		27. Mannef of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	ow injury occurred	
DIVISION OF VITAL	al or Atter after des Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury · At he building, etc. (Specify		reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exami	rician. To the best of my knowner: On the basis of examinal and manner stated.	wladge, death tion and/or in	r securred at the tir vestigation, in my o	ne, date and pl pinion, death o	and and due to the occurred at the time, o	time(c) and manna date and place, and	due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signed (M	
			leyen	c b	ana	D 9	5065	53	4-5-	2006
			30. Name and address of person who co	empleted cause of death (Item	23a) (Type.	Print) GV	IN C	C1/121	ALAC	
			· · · ·	e church	ton	Road	De	eale m	1P. 20	751
The State of the S	Sta Registi		31. Date filed (Month, Day, Year) APR 5 20	32. Pegistrar's Signa	ture	ante				

Henry Evans

			Please Type or Print in Black Indelible Ink. Ensure All	_	_	
			1- State of Maryland / Department of Health and Me Registrar Certificate of Death		g.No.006	11618
	Physici /Medi		Honny Too Even	2. Date of Death Month March	Day Year 28 2006	3. Time of Death 5:40 PM
	Examir		4a. Facility Name (If not institution, give street and number) Genesis HealthCare - The Pines Easton		4c. County of Deat	th
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 20-16-9910 X M 2 F 79 Yrs. Hours Min. 19 Usual Residence of Decedent	8. Date of Birth (Month, Day, 8 – 2 – 1	rear) Co	hplace (State or Foreign wintry) Michaels, Mo
	e Maryland Be-f show	ctor	10a. State 10b. County 10c. City, Town or Location St. Michaels			10d. Inside City Limits 1X Yes 2 □ No
	ath with the 236 or 24	Funeral Director	109 E. Maple Street 21663		Og. Citizen of What Co	ountry?
920	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "netural", or Items 23e or 28e-f show event, Ite Medical Exacting County.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Riff Yes, Give Year or Dates:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:Wh	e, etc.
21215-0036	within 72 ho iene. • then "netui It e Medicui	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver	g 1	6b. Kind of Business/	
Maryland 2	ta de de	To Be Co	4 years 17. Father's Name (First, Middle, Last) Joseph R. Evans Lucy Se		laiden Sumame)	
	s 1 and 2 should if Health and Men item 27 is marke other treumatic.		19a. Informant's Name/Relationship (Type, Print) Patricia L. Evans (wife) 19b. Mailing Address (Street and Number or Rural) 109 E. Maple St., St.			
Baltimore,	0 0		20a. Method of Disposition 1 Sural 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Olivet Cemetery 4-3-2		oc. Location - City or St. Micha	
Bal	permit. Pag Department Importent: fi any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility R. Carroll Hurley 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode Brong, such as cardias of			
	Physician /Medical		Immediate Cause (Final disease or condition a	⊤enspiraktorny-amre:	gaers, M	Interval Between Onset and Death
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68760,	icate be executed physicien and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Colon Concer Due to (or as a consequence of): d.			4 mos-
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rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	the cause of death?
		Completed	Diabetes Hellitis	24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
Vital	sicien: Certifical	o Be (25. Was case referred to medical examiner? Hospital: Hospital: Other: Other:	Check only one)	
of	Attending Physicien: r death. ector: After this certific: by the funeral director.	ertification: To	27. Manor of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? Injury M 1 Yes 2 No		nce 6 Other (Spec v injury occurred	ify)
Division	oitei or Attenours after deathurs after deathurel Director:	0	4 Homicide building, etc. (Specify)	City or Town,		
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, dat	te and place, and due	to the cause(s)
	witi Cor	Σ	29b. Signature and title of certifier MASW 500 H93557		d. Date signed (Month $93 - 29 - 2$	

State Registrar

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

2581 A SCHILL S 555

31. Date filed (Month, Day, Year)

MAR 3 1 2006

MAR 3 1 2006 'Cynurod or Eoston MD 21601

06-02328							
Eder,	Kenneth						

Please Type or Print in Black Indelible Ink

Kenneth		State of Maryland / Department of For State State of Maryland / Department of Certificate of Ce		tai Hygiene	free !	006 161
	R	Registrar	n Death	2 Date	Reg. No of Death	3. Time of Death
Physician		1. Decedent's Name (First, Middle,Last)		Month		ear 17:06
al Examine		Kenneth Andrew Eder 4a. Facility Name (if not institution, give street and number) Union Hospital	4b. City, Town, or Location of Elkton		4c. County Cecil	y of Death
2		7 (In the little down)	If Under 1 Year If Under	er 24Hrs. 8. Date	e of Birth (MM/DD/YY)	YY) 9. Birthplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last billinday) 218-84-0061 1 X M 2 F 37	Months Days Hours	Min.	ne 30, 1968	Country)
v any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once	5	Maryland Cecil Elkton	406 Zin Code		10g. Citizen of V	4
Mary 28a-	Director	10e. Street and Number	10f. Zip Code			
th the Maryland 23a or 28a-f sho notified at once.		293 Hollingsworth Manor	21921 Vas Decedent of Hispanic Original	gin? (Specify Ye		d States ce - American Indian, Black,
2 should be filed within 72 hours after death with the Maryland b and Maryland and and Hygiene. Tris marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	runerai	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	Yes, specify Cuban, Mexican	n, Puerto Rican, e		nite, etc.
ral",	2	or Dates:	Yes 2 X No specify.	_		Business/Industry
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in 72 han '	<u>ə</u>	2	tomer Service		Reta	ail
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tal Hyked o	Re	Alfred W Eder, Sr.			Landrum	
Men Mar mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Nur			
ages 1 and 2 should be filed within 72 and 1 feet and 1 feet and Mental Hygiene. I. filem 27 is marked other than 'et. filem 27 is marked other than other traumatic event, the Medical			South Tartan		00 1 1	ryland 21921 on - City or Town, State
Heal Titem		20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 Cremation 3 Removal from State crematory or	osition (Name of cemetery, other place)	April April	8,	II - City of Town, State
Pages 1 nent of H ant: If i		4 Donation 5 Other Specify: Elkton C	emetery	2006	E1kto	n, Maryland
parumit Pages I Department of I Important: If i		21. Signature of Funeral Service Licensee	Name and Address of Facilities Home for	ty Funeral	ls, P.A.	
o 립러트를 Physician		Muster Musks) (Marman) 23a/Part I. Enter the disease, or complications that caused the death. Do not enter	03 W. Stockto r the mode of dying, such as			Maryland 21921 heart Approximate Interval 8 etween Onset and
/Medical Examiner		In Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	OSIS USB3SB —			Death
oU, te be executed yysician and burial - transit	Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED Due to (or as a consequence of): d. X AMENDED item#23a,PII,pe:	ME,g855,5/5/06 I	T	00 L D	
Division of Vital Records, P.O. Box b&/bU, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 0 Unknown	Fetal death 3 Ector Other (Specify)	pic pregnancy	Month Month	e of delivery h Day Year
GO The at the at the at for	hys	5 Olkiowi	se underlying cause given in l	Part I 23	Be. Did tobacco use co	ontribute to the cause of death?
P.O. es that th igned by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the Diabetes Mellitus	le underlying cadac giver in t		1 ✓ Yes 2 Nc	
S, F	edi	Diabetes Meliitus		24	4a. Was an 24	b. Were autopsy findings available
ecord le law req te has bee	Completed	Arteriosclerotic cardiovascular disease		1	autopsy performed? ✓ Yes 2 No	prior to completion of cause of death? 1 ✓ Yes 2 No
II R		25. Was case referred to medical		th (Check only on		
Vita ysicia his ce direc	o Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpat	ent 3 DOA Other	_		
on of wading Phath	tion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time	of Injury 28c. Injury at Wo	_	Describe how injury oc	curred
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, so (Specify)	street, factory, office building,		ocation (Street and Nu r Town, State)	umber or Rural Route Number, Cit
the Hosp hin 24 ho the Fune	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of the control one) Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and tigation, in my opinion, death	place, and due to occurred at the ti	o the cause(s) and man ime, date and place, a	nner as started ind due to the cause(s)
To To	Me	and manner stated. 29b. Signature and title of certifier	29c. License numb	er	29d. Date s	signed (Month, Day, Year)
		(alabour	O.C.M.E.		April 5,	2006
2		30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Po	enn Street, Baltimore,	MD 21201		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	horally 1			
Regis	ıra		Goodis			
HMH 17 Rev 1/2 CME 10/2003	001	ORIG	NAL			

			1 - For State Registrar	State of Marylan	•	artment of H rtificate of			ene g. No.	6 11620
	Physici /Medic		Decedent's Name (First, Middle, Last) HERMAN HOMER F		R.			2. Date of Death Month	_	3. Time of Death 2:07 PM
· Section of	Examir	er	4a. Facility Name (If not institution, give WASHINGTON COU		L		or Location of Dear	th	4c. County of	
	Funeral Director		210-34-0347 /	7. Age (In yrs. 70)	• • •	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)935	9. Birthplace (State or Foreign Country) MD
	e Maryland 8s-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County WASHING		y, Town or Lo					10d. tnside City Limits 1 ☑ Yes 2 ☐ No
	th with th	al Dire	10e. Street and Number 16309 AYRSHIRE	CT.		10f. Zip Code 21740)	10	g. Citizen of Wh	nat Country? SA
980	be filed within 72 hours after deeth with the Maryland stal hygiene. Id other than "naturel", or terna 23a or 28s-f ehow event, the Mudical Exertions must be multiled at	by Funeral I	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. WHITE
1215-0	within 72 ho ene. than "natur the Medical I	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	rking	6b. Kind of Busi	iness/Industry OF ROCKVILLE
land 2	should be filed to dental Hygis marked other i matic event, II	To Be Co	17. Father's Name (First, Middle, Last) HERMAN H. FITZ	WATER	ADDI	DIANI L	18. Mother's Na	me (First, Middle, M IE V. CU	aiden Sumame)	
Baltimore, Maryland 21215-0036	t 1 and 2 s Health ar tem 27 is other trau		19a. Informant's Name/Relationship (Ty LUCILLE FITZWA 20a. Method of Disposition	TER/SPOUSE	163	09 AYRS	SHIRE CT	Date 2	RSTOWN	MD 21740
altimo	permit. Pages Department of Important: If It eny injury or o		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Set Le Licons		22	natory or other pla IN CEMET Name and Addre ILTON F	ess of Facility		ROCKVI	LLE, MD
8	80559		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat	P	O. BOX	. 86, B <i>I</i>	ARNESVIL		20838 Approximate Interval Between
8760,	Physician /Medical Examiner but still prical examiner still prical still prical examiners and still pr	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uerios of):	sep				
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rds, P	8 6 9	5	Part It. Other significant conditions cor		-		ven in Part I.			ute to the cause of death?
Vital Records,	The law ate has b page 2 s	Completed	Diubetes	mellitu	2			24a. Was an autopsy perform	ed2/ pri	ere autopsy findings available or to completion of cause of ath? Yes 2 \(\sum_{No} \)
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Division of	Jing After fune	-	27. Manner of Death 1 Death 2 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui		dome 5 Resider 28d. Describe hov		
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	To the Hospital within 24 hours a To the Funerel Completely filled	edical	(Check only 2 Medical Examination)	sician: To the best of my kno ner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	ppinion, death occi	urred at the time, da	e and place, an	d due to the cause(s)
	To the within 2 To the complet	¥	29b. Signature and title of certifier	مم وس		29c. Licens	2588	03	d. Date signed ((Month, Day, Year)
3)		30. Name and address of person who co	empleted cause of death (Iter 30 A 251 E 32. Registrar's Signa	n 23a) (Type,	Print)	st, H	agerston	שח חם	21740
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2	32. A gistrar's Signa	iture.	borte				

Dhygiai		Registrar			Certificat	IC OI L				Reg. No.		
	· .	1. Decedent's Name (First, Middle,	Last)					2	2. Date of De Month	ath Day	Yea	3. Time of Death
Physici /Medic	_	Goldie Ir	ene Fr	rost					APRIL	6	2006	2:05 a
Examir	er.	4a. Facility Name (If not institution,	give street and number	7)	4b. City,	, Town, or	Location of	Death		4c.	County of De	eath
gar.	× .	St. Mary's Hos		// / hi-h	to de la la la la la la la la la la la la la	Le	onard					Mary's
uneral			6. Sex 7. A 1 ☐ M 2 X ☐ F	ge (In yrs. last birti	rs. Months		Hours	Min.	B. Date of Bir (Month, Da	iy, Year)		Birthplace (State or Forei Country)
rector		181-14-6848 Usual Residence of Decedent		85				J	July 2	4,19	ZU Pe	nnsylvania
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"natural", or items 23a or 28a-f ahow olicel Examinar must be notified at	ţō	Marvland St.	Mary's		Mec	hani	csvil	م ا				1 □ Yes 2 X N
5 5	Directo	10e. Street and Number	1141			p Code	COVIII			10g. Citi	zen of What	Country?
A T		39209 Birch Ma	nor Drive			20	659			Ut	nited	States
Ē	Funeral	11. Maritat Status	12. Was Deceden Armed Forces		13. Was Dece	edent of Hi		in? (Spec	rfy Yes or No			merican Indian,
		1 Never Married 2 Marrie			1 ☐ Yes		Specify:	, 00110 111	10411, 010.7			White
	d by	3 ☐ Widowed 4 🗓 Divorced	Year or Dates	:		- 22						
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Taur.	1	19a. Informant's Name/Relationshi	7.45		Mailing Address							
other traumatic		Donna Richards 20a. Method of Disposition	/ Daughter	The second secon	209 Bir Disposition (Na.		anor I	rive) Da				e MD 20659 or Town, State
		1 ☐ Burial 2 X Cremation	3 Removal from State	remeter	y, crematory or o	other plac	e e)	- Du		200. E0	ocation - City	or rown, state
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		23a. Part1. Enter the disease, or of shock, or heart failure. List of	only one cause on each	line.	ot enter the mod	de of dvin	g, such as c	ardiac or	respiratory a	rrest.		Approximate
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DHMH 17 Rev 1/2001

GOLDIE IRENE FROST

			Please Type or Print in Black Inc State of Maryland / Depa		•	
			1 - State Registrar Cer	tificate of Death	Reg. No	006 11622
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Russell Franklin Fadeley	1	2. Date of Death Iarch 20	у, 20°0°6 3. Time of Death 0105A м
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	. County of Death
	Funeral Director		University of Maryland Hospita 5. Social Security Number 227-10-9127 Maryland Hospita 7. Age (In yrs. last birthday) 92 Yrs.	L Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Iarch Day Year	9. Birthplace (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	eation		10d. Inside City Limits
	Ba-fet	Director	MD Charles Waldor			1 ☐ Yes 2 XNo
	with th	Dire	10c. Street and Number	10f. Zip Code	10g. Ci	tizen of What Country?
	ne 23	Funerai	11665 Doolittle Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. W	20602 Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F	icify Yes or No-	USA 14. Race - American Indian,
980	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural" or Itame 23a or 28a-1 ehow event, Ira Medical Examinat must be notified at	by Fur	1 Never Married 2√ Married 1 TYes 2 1√ No	Yes, specify Cuban, Mexican, Puerto P	Rican, etc.)	Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	thin 72 ho e. en "natu Medical	Completed by	(Specify only highest grade completed) (Give iife. L	ent's Usual Occupation kind of work done during most of workin DO NOT use retired) Filer	ng	aw Mill
121	ited Tygi Ther		4 Jaw 17. Father's Name (First, Middle, Last)		(First, Middle, Maider	
lan	should be filed within the Mental Hygiene. marked other than umatic event, Ine M	To Be	George Franklin Fadeley		ane Math	
Mary	a a a		, , , , ,	g Address (Street and Number or Rura		
e, N	item 27 l		20a Method of Disposition 20b. Place of Dispos	Well Spring Ct		ta, MD 20646
mor	Pages ent of nt: If it ry or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	natory`or other place) ge Baptist 3/25	6/06 Por	t Deposit,MD
Balti	permit. Pages. Department of H Important: If ite eny injury or of		21. Signatule of Funeral Service Licensee M00945 22	Name and Address of Facility AREHART -ECHOLS	FUNERAL	HOME, P.A.
rsi.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	ir the mode of dying, such as cardiac o	r respiratory arrest,	Approximale Interval Belween Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	tracture.		
1 St.	Examiner		Due to (or as a consequence of):	Age	. 1/1	·
2.50	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		11/1	
	be executed ician and burial-transit	Examiner	cause (Disease of Injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	·	(Chi	
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c 687	entifica ing ph e as th	Med	IF FEMALE:	- Allen		
.O. Box	that the death certificate bed by the attending physic detached for use as the b	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Ω.	quires that the signed by ald be detacted	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		use contribute to the cause of death?
of Vital Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
/ita	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
	S 5	. To	1 XYes 2 No Hospital: 1 X Inpatient 2 □ ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Residence 28d. Describe how inju	
Division	or Attending after death. Director: After in by the fune	Certification:	1 \square Natural 5 \square Pending (Month, Day Year) Injury 2 \times Accident investigation $3/15/06$ 1300	Work? M 1 ☐ Yes 2 ☐ No	Fell in	hathroom
ivis	al or Attendir safter death. I Director: Af d in by the fu	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)		28f. Location (Street a. City or Town, Stat	nd Number or Rural Roma Turbor f
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	al Ce	assisted L 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death			little Dr. MD
	he Ho in 24 h he Fui pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated.	estigation, in my opinion, death occurre	ed at the time, date an	d place, and due to the cause(s)
	With To t	Σ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
0			30. Name and address of person who completed cause of death (Item 23a) (Type, I	17223 Print) 22 South Gre		3,24,06. Ral+ M
1	b 16		RGREWAL UNIVERSITY	OF MARYCAN	γ . 21	201
150	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 9 2006 MAR 2 9 2006	hoose	-	
DH	MH 17 Rev 1/2		MINIT IS O LUUY PROBLES SS. A.	DEP CLI		

		•	State Registrar	,	artment of Health and Mertificate of Death	lental Hygie	211116	1623
	Dhysisi	2.0	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic			oringer		March 31		2228 M
	Examin	er	4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Death		4c. County of Death	
H			Talbot Hospice House 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Easton If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Talbot 9. Birtho	place (State or Foreign
	Funeral Director		212-28-2825 ^{1□M} ¾		Months Days Hours Min.	(Month, Day, Ye	1930 Mary	ntry)
			Usual Residence of Decedent	10.00				IOd Javida Oita Limita
	arylar ehow	_	MD Talbot	10c. City, Town or L	_			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	Directo	MD Talbot 10e. Street and Number		Trappe	100	. Citizen of What Cour	
	with t		4118 Main Street		21673		ited Sta	
	Jeath The 23	Funeral	11 Marital Status 12. Wa		. Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ	can Indian,
٥	or Ite		1 Never Married 2 Married 1	ned Forces? Yes 2 ☑ No es, Give	1 ☐ Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White,	
200	ural',	d by	3 X Widowed 4 Divorced Yea	ar or Dates:				ite
<u>.</u>	"nati	ete	15. Decedent's Education (Specify only highest grade comp	leted) (Giv	edent's Usual Occupation e <i>kind of work done during most of work.</i> DO NOT use retired)	ing	b. Kind of Business/In	
7	withir ene. than	Completed	Elementary/Secondary (0-12) Col	logo (1 Apr E i)	scal Clerk	P	otor Vehic	ie Admin.
Maryland 21215-0036	Hygi other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Mai	iden Sumame)	
<u>Jar</u>	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Theylanes 23a or 28a-f ahow marked other than "natural", or Items 23a or 28a-f ahow martic event, Ita Madical Examinar must be notified at	To B	Henry Miller		Anna	E. Ady		
ar)	2 sho and I Is ma		19a. Informant's Name/Relationship (Type, Prin	•	ling Address (Street and Number or Rura		-	
2`	and lealth m 27 her tr		Leslie Foringer/D	aughter 41	18 Main Street,		MD 2167 c. Location - City or To	
altimore,	iges 1 nt of th i if ite or of		20a. Method of Disposition 1	I from State	ematory or other place)		eston, Mai	
	it. Pa trimer srtant njury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		ruci ocm.			
Ba	permit. Pages 1 and 2 should be Department of Heatth and Menta Important: If Item 27 is marked eny Injury or other traumatic evonce.		m. 1. 2. 91	Zew !	22. Name and Address of Facility Fra 216 N. Main St., Fe	amptom Fun ederalsbu	neral Home ro MD 216	, P.A.
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		ian Cancer			Onset and Death
	/Medical		resulting in death)	ue to (or as a consequence of):	THE CANCE			yws
I	Examiner		Sequentially list conditions, b					
	ed sit	nlner	cause (Disease or injury	ue to (or as a consequence of):				
	execut and al-trar	Examin	that initiated events c.	ue to (or as a consequence of):				
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89	tificat ng phy as th	Medi	IE EELIN E		400			
Вох	eath certific attending p	an/h		es, outcome of pregnancy Live birth 2 Petal death 3	☐Ectopic pregnancy		23d. Date of deliv	ery Day Year
o.	the all	Physician/Me	1 Ves 2 No	Pregnant at time of death 5 Unknown	Other (specify)			22,
P.0	that the de ned by the a detached f	Ph	Part II. Other significant conditions contributing	g to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute lo t	the cause of death?
ds,	w requires that been signed I should be det	d by	Α .	illation, T	Tre 2 Diabetes	1 ☐ Yes	2 □ No 3 Prol	bably 4 ∐Unknown
S	w req	lete	Rheyme	toid Arthr	1+10	24a. Was an	24b. Were autr	opsy findings available ompletion of cause of
Re	The lay te has age 2	Completed	i ica me	-10(a / 1 / 10)*	715	autopsy performe 1 Yes 2	d? death? ¶No 1 ☐ Yes	
Ta.	ysician: The is certificate hadirector, page	Be C	25. Was case referred to medical		26. Place of Deat	h (Check only one)	12 103	20140
>	Physici this ce al direc	To	examiner? 1 Yes 2 No Hospita	: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing Ho	me 5 🗆 Residenc	ce 6 Other (Speci	W) Hospice
Č	Ing PI		27. Manner of Death 28a 1✓Natural 5 ☐ Pending	Date of Injury 28b. Time (Month, Day Year) 1njury	Work?	28d. Describe how	injury occurred	
<u>s</u>	Attending Physician: r death. ector: After this certifice by the funeral director. I	cati	2 Accident investigation	Diagonal Lainer At home form	M 1 Yes 2 No	29f Location (Street	et and Number or Run	al Pouto Number
Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	City or Town, S		ar noble Number,
_	spital nours neral filled		29a. Certifier 1 Certifying Physician:	To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the caus	se(s) and manner as :	stated.
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examinar: Or	the basis of examination and/or d manner stated.	investigation, in my opinion, death occur	red at the time, date	and place, and due t	to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	1	29c. License number	29d	. Date signed (Month,	Day, Year)
)				John MS	1547492		4/3/	2006
			30. Name and address of person who complete JEFFREY DENTON,	M - D. 553 C	Print) PRIVE, 1	EASTON,	MO 216	0/
	C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				•
7	Regist		APR 0 3 2005					

			For State Registrer	State of Marylar		epartment of H Dertificate of L		ental Hygier Reg.	-000	11624
	Physici	an	Decedent's Name (First, Middle, La PARISH	GRIMES					Day Yeer 7 700	3. Time of Death 6 07:40 M
	/Medic Examin Funeral Director	er	4a. Eacility Name (If not institution, given the second of	TAN (+05/17)		Months Davs	ALTIMONIFUL DE LA CONTROL DE L	B. Date of Birth (Month, Day, Yea	4c. County of Dea	
	how how		Usual Residence of Decedent 10a. State 10b. County			or Location				10d. Inside City Limits
	the Ma 28a-f s	recto	MD PRINCE (GEORGE'S	BOWIE	10f. Zip Code		10a. (Citizen of What C	1 ★ Yes 2 No
	23a or	al Di	405 Jaystone Co	urt		2072			U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Excitation could be notified at ADGE.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	J.S.	13. Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 21 No	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Wh Specify: B.	ite, etc.
21215-0036	n 72 ho "natur	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(6	ecedent's Usual Occupa Give kind of work done d ife. DO NOT use retired,	luring most of workin		Kind of Busines	s/Industry
212	ed within giene.	Comp	Elementary/Secondary (0-12)	College (1-4or 5+) 4 yrs		ENIOR BENFI	T SPECIAL		PRIVATE	
and	d be file antal Hy cad oth c event	Be	17. Father's Name (First, Middle, Las. THARMON PERCEI				18. Mother's Name JOYCE A	(First, Middle, Maid NN WHITAK		
Maryland	nd 2 shoul lith and Me 27 is mark r traumati	으	19a. Informant's Name/Relationship GREGORY GRIMES/H			Mailing Address (Street a				
altimore,	Pages 1 au nent of Hea ant: If itam ury or otha		20a. Method of Disposition 1 🗷 Burial 2 Cremation 3 [4 Donation 5 Other (Speci	Removal from State	cemetery,	Disposition (Name of crematory or other place ECTION CEME	TERY 4/1/	2006 CL	Location - City o	ARYLAND
Balt	permit. Departr Imports any inju		21. Signature of Particlal Service Little	nsee		22. Name and Addres	s of Facility J. OVER ROAD			
	Frysician /Medical Examiner	iner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	one cause on each line.	quence of	Mychom		respiratory arrest,		Approximate Interval Between Onset and Death
68760,	ficate be executed g physician and as the burial-transit	edical Examiner	that initiated events resulting in death) Last	c	quence of));				
.O. Box 68	death certif e attending d for use a	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death	3□Ectopic pregnancy 5□ Other (specify)			23d. Date of de Month	l elivery Day Year
4	quires that n signed b uld be deta	by	Part II. Other significant conditions	contributing to death but not re	sulting in t	he underlying cause give	en in Part I.		o use contribute 2 □ No 3 □ F	to the cause of death? Probably 4 Unknown
Vital Records,	: The law requires that the cate has been signed by Ihi, page 2 should be detache	Completed						24a. Was an autopsy performed 1 Yes 2X	death?	autopsy findings available completion of cause of section 2 No
Vit.	Physiclan: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 €	ER/Outp	vatient 3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Hom	(Check only one)	6 □Other (Sp	ecify)
on of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigator	28a. Date of Injury (Month, Day Year)	28b. Tir Inji	me of 28c. Injury	at 2	8d. Describe how in		,,
Division of	al or Attanding s after death. I Diractor: After d in by the fune	ertification:	3 Suicide 6 Could not 4 Homicide determined	De Blace of Injury Ath	nome, farm ify)	n, street, factory, office	2	8f. Location (Street City or Town, St		Rural Route Number,
	To the Hospital or Attant within 24 hours after deatl To the Funaral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, ation and/	death occurred at the tim or investigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cause d at the time, date a	(s) and manner a and place, and du	as stated. ue to the cause(s)
)	To the within 2. To the complet	Σ	29b. Signature and title of certifier	Whosrow	JAB,	ASSI 29c. License	16356	29d. I	Pate signed (Mor ARCH &	17, 200 6 17, 200 6 10, 21239
C	2 (3)		7.77	BASSI, MO	m 23a) (T	9601 L	OCH RA	ven Bhu	D PA	10 21239
Ŀ	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 0 200	2. Registrar's Sign	ature	cele				

			1 - For State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of H			ene	6	11625
			1. Decedent's Name (First, Middle, Las.	1)				2. Date of Death		Year	3. Time of Death
	Physici /Medic		Ardell C. Garr	ett				March		006	11:47a ^M
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea	ath	4c. County	of Death	
			Washington Adven 5. Social Security Number 6. Se			Takoma P If Under 1 Year		2 1 2 2 (2	Monte		
ľ	Funeral Director			7X DM 23© F 7.A	ge (In yrs. last birthday) 102 Yrs.	Months Days	Hours Mir	1. (Month, Day,		Cour	
			Usual Residence of Decedent		102			May 16,	1903	Virg	ınıa
	how	_	10a. State 10b. County		10c. City, Town or Lo				_	1	Od. Inside City Limits
	Ba-f s	cto	D.C.		Washing	ton					1 XYes 2 No
	with th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of \	What Cour	ntry?
	s 238	- La	1747 Allison Stre		Suprimit C	200		0# WN	USA		
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23e or 28e-1 show other traumatic avant, the Madical Executed rights be rediffied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tes 2 If If Yes, Give Year or Dates:	? K No	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (n, Mexican, Pue Specify:	orto Rican, etc.)		ck, White,	can Indian, etc. Lack
21215-0036	tural	edt	15. Decedent's Edi			dent's Usual Occupa	ation		6b. Kind of B	usiness/In	dustry
212	nin 72 an" ni Medik	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or	(Give	kind of work done o DO NOT use retired	luring most of we	orking	oo. Kara or b	201110032111	dustry
212	e filed within al Hygiene. I othar than " vant, the Mei	mo	12	College (1-401		Clerk		I	ederal	Gov	ernment
pu	al Hygid I othar vant,	Bec	17. Father's Name (First, Middle, Last)			THE STATE OF THE S	18. Mother's Na	ame (First, Middle, N			
<u>ya</u>	ould b Ments arkad atic a	To I	Bernard Martin,	Jr.			Emma L	ee			
Maryland	2 should be f n and Mental I 'Is markad of raumatic ava		19a. Informant's Name/Relationship (T)	*				Rural Route Number,			·
	l and fealth im 27 ther ti		Ronald Wilkinson/G	randson	1 / 4 / I		t., N.E	. Washingt			017
altimore,	iges or of		20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ F		cemetery, cren	natory or other place	· .		loc. Location -		
量	permit. Pa Departmer Important: any injury		 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License 		Fort Linco	oln Crema . Name and Addres		30/2006 I	Brentwo	od, l	M.D.
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra QDCB.		+alph V	J. Me	lle	546f kina	oln Fund ensburg	eral Home Rd., Brei		MD	20722
г			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause ne cause on each l	line.		,		st,		Approximate Interval Between Onset and Death
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	Examiner		ſ	Due to (or as	sa consequence of):	heart	a de	- 1 1 - 0			
		er	Sacuantially introductions if any, leading to immediate	Due to (or as	s a consequence of):	arm	ne de	run			
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	. dev	untra						
oʻ	exection are are are are are are are are are are		resulting in death) Last	Due to (or as	a consequence of):						
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o.	the de	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	it time of death 5□	Other (specify)					
Δ.	es that igned by be deta	y Ph	Part II. Other significant conditions co	ntributing to death	but not resulting in the ur	nderlying cause give	n in Part I.	23e. Did tob	acco use cont	ribute to th	ne cause of death?
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CO	aw requir as been s 2 should	Completed						24a. Was an			psy findings available
Be	The lav	lmo						autopsy perform	ed2	prior to cor death? □ Yes	mpletion of cause of
ţa		Be C	25. Was case referred to medical				26. Place of De	eath Check onl one	1		20140
	ys dii	ToE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati	ent 2 ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nursing	Home 5 ☐ Resider	nce 6 Oth	er (Specify	1)
n o	ding Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Da	ury 28b. Time of Injury	28c. Injury Work		28d. Describe how	v injury occurr	ed	
Sio	ttandi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	00 00 (1			'es 2 □ No	201 1			
Division of	I or Attand after deatl Director: I in by the	Certification;	4 ☐ Homicide determined	building, e	jury - At home, farm, stre tc. <i>(Specify)</i>	eet, factory, office		28f. Location (Str. City or Town,		er or Rura	i Route Number,
-	To the Hospital or Attanding Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, death	occurred at the tim	e, date and plac	e, and due to the car	use(s) and ma	nner as st	ated.
	he Hc in 24 l he Fu bletelly	edical	(Check only 2 Medical Exami	ner: On the basis of and manner si	of examination and/or inv	estigation, in my op	inion, death occ	curred at the time, da	te and place,	and due to	the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	1		29c. License	number		d. Date signed		
•	4		> Stuu	1lle		046	498	1	11426	128	3,2006
1	7		30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type,	Print)	T 11.	11041	1. 4	n	A7A-
2			31. Date filed (Month, Day, Year)	A 39 Ragies	ar's Signature	VIITURU S	of thy	14 413 111	IX M	UZ	0182
	Sta Registr		MAR 3 0 2006	Been !	& And	•					

State of Maryland / Department of Health and Mental Hygiepe [] [Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March **Physician** 2006 07:45 Charles W. Gross Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Genesis Elder Care @ Spa Creek Annapolis 7. Age (In yrs. last birthday)

86 Yrs.

Nonths Days Hours Min.

8. Date of Birth (Month, Day, Year)

Apr 6 191 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 1919 Maryland Director 220-09-2871 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f ehow any Injury or other traumatic event, the Madical Experiment must be notified at TXXYes 2 No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1995 Reidville St. 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1943 – 46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) United States Elementary/Secondary (0-12) 12th College (1-4or 5+) Cook Manager Naval Academy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George O. Gross Annie E. Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeffrey Gross(Son) 1995 Reidville St. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veteran 4-3-06 Crownsville, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Wm. Reese & Sons Mortuary, P.A. Zarry H. Reese MOO 183 821 West St. Annapolis,

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death multiple ony cloma Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No page 2 should be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 5 Pending ne Hospital or Attendin 124 hours after death. The Funerel Director: Aft 1 ☐ Yes 2 ☐ No М investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) 30. Name and address Didnet are it 20 31. Date filed (Month, Day, Year) State 2006 Registrar

			For State Registrar	State of Marylan	-		of H	ealth a		ental Hy	giene	06	11627	
ρΣ,			Decedent's Name (First, Middle, Last)							2. Date of De	ath		3. Time of Death	_
	Physicia	- 5	John Gnall							Month March	24, 2	Year 2006	10:10A	
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location of				ounty of Death		
			11953 Andrew Stre					Spring				ntgome		
¥.61	Funeral		Social Security Number 6. Sex	M 2DE	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th y, Year)	Cou		7
	Director		168-14-6664 Usual Residence of Decedent	85	115.					Aug. 4	, 1920) Pen	nsylvania	-
3	ow #		10a. State 10b. County	10c. City	, Town or Lo	ocation							10d. Inside City Limits	
	Mary	to	Maryland Montgomer	ry Si	lver S	pring							1 ☐ Yes 21 No	
	or 28g	Funeral Director	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Cou	ntry?	
9	23a c	alD	11953 Andrew Street				902					SA		
1	tems	ner	1. Maria Garas	12. Was Decedent Ever in U. Amped Forces?	S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	ispanic Orig n, Mexican	jin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14	 Race - Ameri Black, White, 		
9	s alle	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∰Yes 2 No If Yes, Give Year or Dates: 1942	-51	1□Yes 2	⊠ No	Specify:			S	pacify:Whit	ce	
3	nour stural	edk	15. Decedent's Educ		16a Dece	dent's Usua	I Occupa	ation			16b. Kind	of Business/Ir	dustry	_
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2	al Hy I othe vent,	Be C	17. Father's Name (First, Middle, Last)							(First, Middle	Maiden S	umame)		
<u>x</u>	Ment Ment arkec	2	Joseph Gnall							elmak				
<u>a</u>	permit. Pages 1 and 2 should be lied within 72 hours affer death with the maryland Department of Health and Mental Hygiene. Department: If them 27 is marked other then "natural", or Items 23a or 28a-f show mnot injury or other traumatic event, the Medical Examinar must be nutitived at once.		19a. Informant's Name/Relationship (Ty) Mary Johanna Bell,									fown, State, Zi _l and 207		
ນັ້	l and lealth im 27 ther t		20a. Method of Disposition		lace of Dispo					Date		ition - City or T		_
5	or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		amatanı cra	maton/ or o	thar niar	e) M	arch 200	28,		-	ng,Marylar	h.c
	ortant		4 □ Donation 5 □ Other (Specify) 21. Signature of Puneral Service License				-			Funera			ng, mary rai	10
ם מ	Deparent Dep		* Kahund Z L	iles	5	00 Un	iver	sity	Blvc	l, W, S	ilver	Spring	, MD 20901	L
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deat ne cause on each line.	h. Do not en	ter the mod	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
å F	hysician		Immediate Cause (Final disease or condition resulting in death)	Atheroscerot		diova	scul	ar Di	seas	e		1	980	_
	/Medical Examiner			Due to (or as a conseq	uence of):							-	000	
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	nslt	E E	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hy erlipidemi								1	980	
,	le be executed yslcien and e burial-translt	Examiner	resulting in death) Last	Due to (or as a conseq										
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	e death the atten ned for u	SICI	1 Yes 2 No	4 Pregnant at time of of 9 Unknown	eath 5[Other (sp	ecify)						- 4,	
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	the H nin 24 the Fi	Medical	one)	and manner stated.					50001					
	To To	2	29b. Signature and title of certifier	1 - NA		290		729				signed (Manth ch 25,		
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	10+	1	30. Name and address of person who co George B. Patric	ompleted cause of death (Item k, III 9221	n 23a) (Type Coles	ville	Roa	nd, Si	.lveı	Sprin	g, MD	20910		
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 9 2	32. Registrar's Sign	ature	parts)	,							

		-	For State Registrar		State of M	larylan		artment o				0	000	110	20
				ame (First, Middle	a, Last)		CE	runcate	UI Deali	1	2. Date of De.		000	3. Time of	Death
	Physicia	an		e R. Gr							MARCE	Day 2:		5 12:36	, PM
	/Medic Examin		4a. Facility Name	(If not institution	, give street and number	r)		4b. City, Tox	vn, or Location			4c. (County of Death		4
			5+.	HIGNE		pita ge (In yrs. I	/) If Under 1 Y		MOR er 24 Hrs.		L		MORE	
	Funeral Director		5. Social Security 225–52–	4678	6. Sex 7. A 1 M 2 XF	•	8 Yrs.		ays Hours		Month, Da	y, Year) 5.19	9. Birth Co. Pitt	sylvan	ia.VA
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	within 72 hours after death with the Maryland ane. then "netural", or Itama 23a or 28a-f ehow ha Medical Exemiliar must be inclified at	Funeral Director		Rokeby Ro	oad			2122	19			Un	ited S	states	
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9	etural	ted	<u> </u>	15. Decedent	t's Education		16a. Dec	edent's Usual C	ccupation	and of words	22	16b. Kir	nd of Business/	Industry	
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Baltimore,	permit. Pege Department Important: If any njury or			on 5 Other (S		nov		Name and Austin					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	., 20	
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			23a. Part1. Ent	er the disease, or reart failure. List	complications that caus only one cause on each	line.			f dying, such	as cardiac o	or respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
	Physician		Immediate Cau disease or cond resulting in dea	dition		IROS		515						HOUR	
	/Medical Examiner			,		as a consequence		7						NA 4 S	
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Ö.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/M	1 Tes		4☐ Pregnant 9☐ Unknown		eath 5	Other (spec	ify)					,	
<u>α</u>	that the		Part II. Other si	gnificant conditi	ons contributing to death	t but not res	ulting in the	underlying cau	se given in Pa	rt I.	23e. Did 1	obacco u	se contribute to	the cause of c	death?
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sior	Attending or death. ector: After by the fune	catio	1 Natural 2 Accider	nt investi	igation			М	1 ☐ Yes 2	□No					
Division	or Attendate death	Certification:	3 ☐ Suicide 4 ☐ Homici	dotorn	nined 286. Place of	Injury - At he etc. (Specif		street, factory, o	office		28f. Location (City or To		d Number or Ru)	urai Houte Num	nber,
_	To the Hospital or Ati within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier	1 Certifyi	ng Physician: To the be	st of my kno	wledge, de	ath occurred at	the time, date	and place,	and due to the	cause(s)	and manner as	stated.	
	the Ho lin 24 the Fu	Medicai	(Check only one)		Examiner: On the basis and manner		ition and/or		icense numbe		ed at the time,		e signed (Mont		»)
	T vit	2		and title of certifie	1/ rich	nar	non		PIZ	1.05	-	0 3	1-21-		
	1 -		30. Name and a	address of persor	who completed cause of VINTAMA, as 22. degi	of death (Iter	n 23a) (Typ	e, Print)			0 * .		/ 1		
	6		SAI	NJAY	VINJAMA	RAM		900 C	enton A	he,	Baltin	nos	re MI	> 2/2	29
	St Regist	ate	31. Date filed (i	Month Day Year	0 2006 32. Fegi	istrar's Signa	ature #	Carle							
	negist	तवा			100	2000	1	-							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Johnny Greene 24, 11:38A M 2006 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner P.G. Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8.
Months Days Hours Min 8. Date of Birth (Month, Day, Year)
10-20-20 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 85 **5€ 1** 2 □ F Va. 229-20-9175 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits with the Maryland 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event. It a Medical Examinational Landellie 2 in once. 1 Yes 2 □ No MD. P.G. Suitland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20746 2405 Darryl Drive #T2 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Private 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosie Tolliver **Ernest Greene** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2405 Darryl Dr. #T2 Suitland, Md. 20746 Euphemia Greene/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Donation 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2 3/31/06 Brentwood, Md. Fort Lincoln 22. Name and Address of Facility
The House of Williams Fun. Svc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the all detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 1 Yes certificete Division of Vital Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: To the Hospitei or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Contilling Physician: To the best of my knowledge death occurred at the time, date and place, and due to the acuse(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 25a. Cartiflet (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0048123 Unterne Dunker. 0.3 2006 ANTWI - DONKOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC 750 9131 ROAD SUITE PISCATAWAY 31. Date filed (Month, Day, Year) MAR 3 0 32. Registrar's Signature State 2006 Registrar

		•	_ State	ate of Marylan		artment of H			ene	11690
4	140 T		Registrar 1. Decedent's Name (First, Middle, Last)			inouto or i	Journ	2. Date of Death	1	3. Time of Death
	Physicia	_	Norman Jos	eph Goodw	in			April 2	2, 2006 Year	11:04 A M
	/Medic Examin	_	4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
	** ***		St. Mary's Hospital			Leonardt			St. Mary	
Ш	» Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. 2 F		If Under 1 Year Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 21,	Year) 9. Bir 1039 Dict	thplace (State or Foreign ountry) rict of Columbia
-	Director		214-36-3230 X M		7			April 21,	וצוע סנפו	rict or corumbia
	filed within 72 hours after death with the Maryland Hygiene. other than "naturel", or Items 23s or 28s-f show ent, the Muclical Exacult or count be notilised at		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	a-fai	ctor	Maryland St. Mary's	Lex	ington	Park				1 ☐ Yes 2 No
	or 26	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
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_	item item	Funeral	11. Maritar States	med Forces?		Il Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, Whi	
920	or', or	by		f Yes, Give rear or Dates:		1 ☐ Yes 2 X XNo	Specify:		Specify: Wh	ite
Š	72 ho	Completed	15. Decedent's Education (Specify only highest grade co.		16a. Dece	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of work	king	6b. Kind of Business	s/Industry
7	ithin se.	nple		College (1-4or 5+)					U.S. Governm	nont-
2	lled w tygier her th	S	17. Father's Name (First, Middle, Last)		Transp	ortation Sp		e (First, Middle, N		eit
auc	m = V =	Be C	William Henry Goodw	in				ennyson		
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Io marked other than eumatic event, Ing M	P P	19a. Informant's Name/Relationship (Type,		19b. Mailii	ng Address (Street			City or Town, State,	Zip Code)
	nd 2 salth ar 27 le		Patricia Ann Goodwin / V	vife .	21067	WindingWay,	Lexington	Park, Mary	land 20653	
re,	of Heal		20a. Method of Disposition		cemetery, crei	osition (Name of matory or other place	⊝) Apri]	Date 2	20c. Location - City o	r Town, State
E	Pages nent of ant: if its ary or o		1 № Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	ivai irom State Cha	arles Me ardens	morial	7, 200		eonardtown,	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 ie marked any njury or other treumatic es		21. Signature of Funeral Service Licensee	1, 1	Ma Ma	2. Name and Addres	ss of Facility rdiner Fund	eral Home.	P.A.	
	205 2 2	Ш	Trickael Herre To	Erdinery		ttingley-Ga O. Box 270,				
×	****		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ons that cause, the deal	th. Do not ent	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Deal
16	Physician		Immediate Cause (Final disease or condition resulting in death)	Hout	& My	goasdu	al Jul	oches)	1	minules
1	/Medical Examiner	,	1000ming in doubly	Due to (br. s conset	(uence of):	A A	Danie 17	7.100	10	//
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	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Friedry that initiated events c.				V			V
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Δ.	The law requires that the de site hes been signed by the a bage 2 should be detached (Part II. Other significant conditions contrib	uting to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ds	puires n sign ald be	d by		4				1 □ Ye	s 2 ₽ No 3□F	Probably 4 Unknown
Records,	aw requir ss been s 2 should	Completed	1	mland	100	1		24a. Was ar		utopsy findings available
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<u>ra</u>		Be C	25. Was case referred to dical examiner?				26. Place of Dea	th (Check only on		
<u>></u>	Attending Physician: r death. ector: After this certifics by the funeral director, I	Tof	1 ☐ Yes 2 No	I 🗆 inpatient 2 🖁	ER/Outpatie		4 140,3119 11		nce 6 Other (Sp	ecify)
ū	ing P Viter t unera		1 Situatural 5 1 Situating	8a. Date of Injury (Month, Day Year)	28b. Time o	Wor		28d. Describe ho	w injury occurred	
<u>s</u>	death tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be	Do Blood of Injury At h	ama lare et		Yes 2 □No	281 Location /St	reet and Number or F	Rural Route Number
Division of Vital	in Diffe	ertification:	4 Homicide determined	8e. Place of Injury - At h building, etc. (Speci		reet, factory, office		City or Town	, State)	nurai riodio ivanibor.
	To the Hospital within 24 hours a To the Funeral I completely filled	0	29a. Certifier 1 Certifying Physicia	an: To the best of my kn	owledge, deal	th occurred at the tir	ne, date and place	, and due to the ca	use(s) and manner a	as stated.
	ne Ho 1 24 h Ne Fui	edical	(Check only 2 Medical Examinar: one)	On the basis of examination and manner stated.	ation and/or in	ivestigation, in my o	pinion, death occu	rred at the time, da	ate and place, and du	e to the cause(s)
	To the within 2 To the Complet	×	29b. Signature and title of certifier		11	29c. Licens	e number	()	9d. Date signed (Mor	nth. Day. Year)
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1	M		30. Name and address of person who comp	/ 1			1 ** 1-	1 15	0606	
/		1	James P. Jarboe, M. 31. Date filed (Month, Day, Year)	D. 24035 32. Registrar's Sign		Notch Roa	ad Hollyw	rood MD 2	0636	
	Sta Regist		APR 4 2008		K A	reals :				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2004 4c. County of Death **Physician** Month March Loretta L. Glenn /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Medical C Wirnia Anni 10-5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 💆 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 ☐ M 2 💢 F 76 Hours 216-28-0899 Yrs Director Mar Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Madical Examinar must be notified at 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 ☐ Yes 2 X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 457 Harlem Ave 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/€Xio <u>\$</u> Specify. Specify: Black ₩Vidowed 4 Divorced is marked other than "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 11th Caregiver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Robert Williamson ages 1 and 2 should b nt of Health and Menta :: If item 27 is marked Emma Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Boone(Daughter) 457 Harlem Ave Pasadena, 21122 Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
sny injury or ott
once. 1 Burial 2 □ Cremation 3 □ Removal from State Carpenter Hill 4 Donation 5 Other (Specify) 3-30-06 Severna Park, Md. 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. Lavry 12. Nee M0048 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a ence of) Examine the burial-transit and Due to (or as a consequence of): 68760, attending physicien for use as the buria Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, icate has been siç r, page 2 should b Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate ! 2 No Vital 1 Yes 1 ☐ Yes 2 No 25. Was case referred to medicat Be 26. Place of Death (Check only one) examiner? Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 2 Accident investigation M 1 Yes 2 No the Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Dire 4 Homicide Hospitel TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

BUA

31. Date filed (Month, Day, Year)

		For State Registrar	State of M	larylar		rtmen tificat			ind M		jiene og. No: 0	06	11632
Physici /Medic Examin	al	Decedent's Name (First, Middle, Last BRADIE DU 4a. Facility Name (If not institution, give	FF G	IBSON		4b. City,	Town, or	Location of	f Death	2. Date of Dea Month	Day 4c. Cour	Year O6 nty of Death	3. Time of Death
Funeral Director			<i>Ned (Col</i> × 7. A □ M 2√ F	ge (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 5-30-19	/ -	9. Birthp	place (State or Fore
8a-f ahow	Director	Usual Residence of Decedent 10a. State 10b. County VA AMHERS	T		y, Town or Loc		GHTS						0d. Inside City Lim
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piene. r than "na ine Medic	Be Completed t	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	ıcation		life. D	ent's Usua kind of wor OO NOT us EMAKE	rk done d se retired)	uring most		(First, Middle,		НОМЕ	dustry
f Health and Mental Hyg Item 27 ia marked othe other traumatic avant,	ToE	LEONARD JAMES DU 19a. Informant's Name/Relationship (7) WAYNE GIBSON / SO	rpe, Print)			-		nd Number	r or Rura	E DUFF / Route Number EORGETO			
nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State		Place of Disposemetery, crem	sition (Nan atory or o	ne of ther place) 	1.5	ate	20c. Location	n - City or To	own, State
Depertment of Important: If its any injury or o once.		21. Signature of Funeral Service Licens	Kelly		B(DIINDS	FUN	s of Facility ERAL N STR	HOME	SALISB	URY, M	D 2180	04
ysician and Wedical the prinal-transit the prinal-transit	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as Due to (or as d.	SIC s a conseq	L 5(v	(An 1~3	sy	ade Indu	om 2	2			Onset and Death
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ete hes been sign page 2 should be	Completed by Pl	Part II. Other significant conditions co	ntributing to death I	but not res	ulting in the un	derlying ca	ause give	n in Part I.		1 TYe	n 24t	3 Prob Were auto prior to cor death?	ne cause of death hably 4 Gunkni psy findings avail mpletion of cause 2 No
ith. r: After this certificete e funeral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manger of Death 1 ☐ Natural 5 ☐ Pending investigation	lospital: 1 Impati 28a. Date of Inj (Month, Da		ER/Outpatient 28b. Time of Injury		Bc. Injury Work	r: 4 🗆 Nur:	sing Hon	Check only on ne 5 Reside 8d. Describe ho	ence 6 🗆 O		v)
urs after des rel Diractor lled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	tc. (Specif	ý) 			III III III III III III III III III II		City or Towr	n, State)		l Route Number,
within 24 hours after death. To the Funerel Diractor: After this completely lilled in by the funeral	Medical	29a. Certifier (Check only one) 29b. Signature and Majories of the control of the control one)	sician: To the best ner: On the basis of and manner si	of examina	wledge death tion and/or inv	estigation,	in my op	inion, death number	n occurre	ed at the time, d	ate and place	e, and due to ned (Month,	the cause(s)
		30. Name and Ludress of person who co	ompleted cause of	death (Item	n 23a) (Type, F	Print)		707-	16	2 Mo	4/8/0	16	

RJ

2057		Please Type or Print in Black In State of Maryland / Dep	artment of Health and I		_
		1 - State Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Do Date of Dooth	Day Year 3. Time of Death
Physi /Med	dical	KEVIN JERMAINE HILLIAN	4b. City, Town, or Location of Death	March 2	3. 1 me of Death 3. 2006 11:23p. M
Exam	iner	43-Facility, Name (If not institution, give street and number) Southbound Route 1/5 near Allentown Road	Clinton		Prince George's
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 215 17 2516 XXXI M 2 F 24 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, OCT. 01,	9. Birthplace (State or Foreign Country) WASHINGTON, DC
Aaryland f show	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD PRINCE GEORGES CLINTON	ocation		10d. fnside City Limits ₩XYes 2 □ No
th the A	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
ath wi	ral	6311 BARNWOOD DRIVE	20735		UNITED STATES
ife, INIGITYIGITY Z 1 Z 1 D-0050 I and 2 should be filled within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic svent, the Madical Exprinter must be explited.	by Funeral	11. Marital Status XXX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXX No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2\lambda No Specify:	респу Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
L 13-UU30 thin 72 hours aff 9. an "natural", or Medical Erain	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king	6b. Kind of Business/Industry
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Vidition ould be file Mental Hy arked oth	To Be	LEE T. HILLIAN		ERYL JACK	
Maryian d 2 should be th and Mental th and Mental 7 is marked traumatic sv	112		ing Address (Street and Number or Ru		
e, IV 1 and 1 Health em 27 ther tr		LINDA B. WELLS/MOTHER 6311 20a. Method of Disposition 20b. Place of Disp	BARNWOOD DRIVE	CLINTON,	MD 20735 Oc. Location - City or Town, State
Pages ent of l		XIXBuriai 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place) TION CEMETERY 04/0		CLINTON, MD
Dermit. Pages 1 and 2 Deportment of Health a important: if item 27 is	Succe	21. Signature of Funeral Service Licensee	P. Name and Address of Facility IARSHALL'S FUNERAL 4308 SUITLAND ROAD	HOME OF	
		23a. Part1. Inter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			st, Approximate Interval Between Onset and Death
Physicia: /Medica	_		njuries		
Examine		Due to (or as a consequence of):	9		
be sit	liner	Sequentially list conditions, if any, team to this consequence of) cause. Enter Underlying Cause (Disease or injury			
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g Phys er this	ا: ا	27. Manner of Death 28a. Date of Injury 28b. Time			v injury occurred Occupantin
DIVISION (I or Attending I efter death. Director: After I in by the funer	catlo	2x Accident investigation 3/23/06 (0:55	PM 1□Yes 2□No		Velucle Collision
lor At efter d Direct	Certification;	4 ☐ Homicide determined determined 28e. Pface of fnjury - At home, farm, s building, etc. (Specify)		City or Town,	eet and Number, ir Rural Royle Number, State) 3.6 F. 5.6
UNISION OT VITA To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: Atten this certifica completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dec 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place	and due to the ca	ise(s) and manner as stated
To the Within To the	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
20		· Carol Halan md	OCME	M	arch 24, 2006
By		30. Name and address of person who completed cause of death (Item 23a) (Type CAROL H ALL AN MAN		t Baltim	ore, Maryland 21201
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature		2 5 7 7	
Regi	1/0001	MAR 3 0 2006 Seem & Specie			

Pages 1 and 2 should be filed within 72 hours after death with the Maryland To Be Completed by Funeral Director To Be Completed by Funeral Director	Jual Residence of Decedent 10a. State 10b. County Md. 10e. Street and Number 2508 Edfeldt Dr 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grantle) 17. Father's Name (First, Middle, Last) William E. Har 19a. Informant's Name/Relationship (7) Mary Black/Daught 20a. Method of Disposition 1 Merical 2 Cremation 3 D	Harris o street and number) TY Hospital P. Mas Decedent Ever in Armed Forces? 1 12 Was Decedent Ever in Armed Forces? 1 12 Was 2 No If Yes, Give Year or Dates: lucation de completed) College (1-4or 5+) Cris	13. 13. 13. 13. 13. 13. 13. 13. 13. 13.	I If Under 1 Year Months Days Docation Strict He 10f. Zip Code Was Decedent of H If Yes, specify Cubs 1 Yes 27 No	20747 dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Og. Citizen of W 14. Race Black Specify:	9. Birthplace (State or For Country) Florida 10d. Inside City L XXYes 2[hat Country? S.A. American Indian, White, etc. African— American		
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Physician /Medical Examiner	23a. Part1. Inter the disease, or companies, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	v o v (•	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Betwee Onset and Dea		
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	/Medic		4a. Facility Name (If not institution, give stre		1	4b. City.	Town, or Location			4c. County of Dea	
	Examin	ier		ty Gen.	Hosp			umbi	es	Howa	
	Funeral		Social Security Number	7. Age (In	yrs. last birth	day) If Under	1 Year If Unde	_			
	Director		158 03 8774 1 TAN	^{2□ F} 86	Yr	S. Months	Days Hours	Min.	July 3	1, 1919 NE	nthplace (State or Foreign Country) W Jersey
	D.		Usual Residence of Decedent								T
	how thow	_	10a. State 10b. County	100	c. City, Town	or Location					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ba-f	cto	MD Howard	(Columb						
	vith th	Dire	10e. Street and Number	Dood		10f. Zip	21044		'	Og. Citizen of What C United St	-
	deeth with the Maryland me 23a or 28a-f show	Funeral Director	5400 Vantage Point	Was Decedent Ever	in III C			rining /Cons	du Vec es No	14. Race - Am	
	item item	ū.	11. Marital Status 12.	Armed Forces?	in 0.5.	If Yes, spec	lent of Hispanic O offy Cuban, Mexica	an, Puerto R	ican, etc.)	Black, Wh	
0000	filed within 72 hours after Hygiene. sther than "natural", or ite ant, the Medical Exemena		3 Note of the state If Yes, Give Year or Dates: 19	41-45	1 ☐ Yes	2 XNo Specify	γ:		Specify: W	hite	
5	2 hou	Completed by	15. Decedent's Educat	ion	16a. C	ecedent's Usua	Occupation	st of working	2	16b. Kind of Busines:	s/Industry
7	thin 7	ηple	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)			rk done during mo se retired)	ist of working			
7	ed wil	Son	-12		Adı	ministr				Federal G	overment
	0 = 0 >	Be	17. Father's Name (First, Middle, Last)						(First, Middle, 1 Joachim	Maiden Sumame)	
<u>X</u>	ould Men Marke Marke Marke	2	Daniel Harrigan								7.01
Mar	12 sh h and 7 le m rraum		19a. Informant's Name/Relationship (Type	-		_				r, City or Town, State, City, MD 2	
e)	1 and Healt In 2 ther		James N. Harrigan/S					Da		20c. Location - City o	
	ages nt of nt of t: With		1 ☐ Burial 2 ØCremation 3 ☐ Rem	iovai irom State		Disposition (Nan crematory or o	1	3-30-	-2006	Catonsvil	
Бапппо	iit. Partme artme ortant injury		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	-		Cremato:					mily FH Inc.
D B	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked eny injury or other traumatic e ance.		Al Colli	- while	01044						, MD 21043
	A 4		23a. Part1. Enter the disease, or complica	tions that caused the	death. Do no						Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final		e natural	L	Pan	um or			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	spiral national property of):	The	WHI CV	14		
	Examiner		b.								
-	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					
	acuted nd trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.								
ລັ	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	EX	resulting in death) Last	Due to (or as a co	nsequence of):					
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×	ding l	/Me	IF FEMALE:	If yes, outcome of pr	regnancy					22d Data of d	
X D D	atten for u	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp				23d. Date of do Month	Day Year
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7	requires that the een signed by th nould be detache		Part II. Other significant conditions contri	buting to death but no	ot resulting in t	he underlying c	ause given in Part	t I.	23e. Did to	bacco use contribute	to the cause of death?
cords,	quires n sign	d by							1 🗆 Y	es 2 No 3 F	Probably 4 Unknown
Ü	w rec	lete							24a. Was a	ın 24b. Were a	autopsy findings available
Ä	sician: The law certificate has b irector, page 2 s	Completed							autops perform	med2 death?	completion of cause of
VITAI		0	25. Was case referred to medical				26. Plac	ce of Death	(Check only on		5 2010
	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No	pital: 1 Inpatient	2 ER/Outp	patient 3 DC	Othor			ence 6 Other (Sp	ecify)
0	ng Ph ter th neral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. Tir	me of 2	8c. Injury at Work?	28	3d. Describe he	ow injury occurred	
<u> </u>	endir eath. or: Al	atlc	2 Accident investigation			М	1 Yes 2	□No			
DIVISION	fter direct	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farr specify)	n, street, factory	r, office	28	8f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
_	urs al										
	Hos 24 ho Fun stely f	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	r: On the basis of exa and manner stated.	y knowledge, imination and	or investigation	at the time, date a , in my opinion, de	and place, area	d at the time, d	ause(s) and manner a late and place, and du	is stated. le to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death of To the Funeral Director; After this certific compietely filled in by the funeral director,	Me	29b. Signature and tiple of certifier			290	. License number		2	9d. Date signed (Mor	nth. Day, Year)
			Kayun	MD		I	00537	09		3/30/2	ω L
- /	U		30. Name and address of person who com	pleted cause of death	(Item 23a) (T	ype, Print)	chawla			4	
	JM		14300 Calla	it Fox	lan	e 5	TE # 2	210	Bowle	m s)	20715
30	Sta		31. Date filed (Month, Day, Year) MAR 3.1 200	32. Registrar's	Signature	1					
14	Registr	ar	13.14.	O PERMA	The state of the s	LATRICE	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death March 2**7,** 2006 **Physician** 4:20 HAROLD HALPERN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Oct. 25, 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1917 Days Hours Months 1⊠M 2□F 135-01-2008 88 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturet", or items 23a or 28a-f show purjerty or other traumstic event, the Madical Examinar must be notified at once. Rockville NOXYes 2 No MD Funeral Director Montgomery 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 20852 11520 W. Hill Dr. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 1 K Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 □ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Proprietor Gallery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Karl Halpern Mary Weintraub 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lynn Seligson/Daughter 11520 W. Hill Drive Rockville, MD 20852 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Enemoval from State 3-30-06 Florida Royal Palm Memorial 4 □ Donation 5 □ Other (Specify) DanmanskyssGtidberg Memorial Chapels, Inc. Te pi Funeral Service Licensee 1170 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrhythmia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Thrive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 X No 24a. Was an autopsy performe 1☐ Yes Attending Physicisn: 25. Was case referred to medical 26. Place of Death | Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 P/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 Yes 2 No death. 2 Accident investigation hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours after To the Funeral Dire completely filled in by Hospital or 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) 106 D54776 Physician Emergency

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Registrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 2 9 2006

32. Registrar's Signature

Coorle

-Conard, MD 8600 Old Georgetown Rd. Bethesda, MD 20814

Physici		1 - For State Registrar #7, per/f.hc 1. Decedent's Name (First, Middle, Last)					2. Date of De			3. Time of	Death
/B # 17.		Jessie M. He	ensley				March	27	Year 200	6 0045A	
/Medio		4a. Facility Name (If not institution, give s		4	b. City, Town, or	Location of Deat	h	4c. (County of Deal		
		Coastal Hospice	At The Lake		Salisb				icomic		
Funeral Director		5/9-09-/32/	7. Age (In yrs. 93 -94		f Under 1 Year fonths Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	y, Year)	7.7 1	thplace (State or buntry) hington	
A =		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Locat	ion					10d. Inside Cit	ty Lim
f eho	Ď	MD Wicomico	S	alisbury						1 Yes	2 🗌
r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?	
23a o	a D	1110 Healthway Dr.	, Unit 207		21804			U	S		
ems E E	Funeral		12. Was Decedent Ever in U Armed Forces?	J.S. 13. Wa	s Decedent of Hi es, specify Cuba	spanic Origin? (S	specify Yes or No to Rican, etc.))- 1	4. Race - Ame Black, Whit		
if Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23s or 28s-f ehow other traumatic event, the Medical Examinar must be notified at	b	1 Never Married 250 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		Yes 2⊠ No	Specify:			Specify: Wh		
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ental ked o	To Be	Norman T. Pyles				Nellie	Russe1				
if Health and Mental Hygiene. Item 27 is marked other then other traumatic event, the Ma	-	19a. Informant's Name/Relationship (Ty	pe, Print)				ow Hill			Zip Code)	
		Randall B. Coates 20a. Method of Disposition		TUD IN • Place of Dispositi cemetery, cremat	on (Name of		Date Date		ation - City or	Town, State	
nent of h ant: If its ury or of		1 ☐ Burial 2 XCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Ca	pe Henlo	-	1	-		kford,		
Depertment of Important: If i eny injury or one		21. Signature of Funeral Service License	y Rabbo	1			e Burbag Berlin,	_		Home	
igned by the attending physicien and igned by the attending physicien and igner in the detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect to the following	quence of):	se					Onset and D	
the attending pried for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√□ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	aldeath 3 ⊟Ed	ctopic pregnancy other (specify)			2	3d. Date of de Month	,	Year
ac 5	5	Part II. Other significant conditions con	ntributing to death but not re	sulting in the unde	erlying cause give	en in Part I.	1	_	_	o the cause of d	
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State of Maryland / Department of Health and Mental Hygiene

			Cert	tificate of	Death		Reg. No.	0	1000	
		Decedent's Name (First, Middle, Last)				2. Dete of De Month	eath Dey	Yeer	3. Time of Death	
Physic /Med		Deborah Hill				Mar.		006	9:30AM	
Exami		4e Facility Name (If not institution, give street end number)			4b. City, Town, or Le	ocation of Deat	h 4c. County	of Deeth		
		Manor Care Nursing Home			Largo					
Funeral			6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Quantity 9. Birthplace (State or F			lace (State or Foreign)			
Director		218-58-2098 1□M 2気F 53	Yrs.			2-2	7-53	N.	Y	
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be notified at	-	Usuel Residence of Decedent 10a, Stete 10b, County 10c. Ci	ity, Town or Loc	ation				1	0d. Inside City Limits	_
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it it	Completed by Funeral Director	10e. Street and Number		10f. Zip Code	740		10g. Citizen of \		ntry?	
eth v	rai	1501 Pine Grove Road			743	// N/ N/		A.	I-di	
er de	L L	11. Merital Stetus 12. Was Decedent Ever in L Armed Forces?	J,S. 13. W	as Decedent of Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)		e - Americ ck, White,		
36 safte	Ž	If Yes, Give	1	☐ Yes 2 🛣 No	Specify:		Specif	Blac	ck	
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altimore, mit. Peges 1 ar partment of Hea portant: If Item ? y injury or other	C>	1			<u> </u>					_
Baltimo permit. Pege Department (important: If any injury or		21. Signature of Funeral Service Licensee	22.	Name and Addr Hacket	ess of Facility t s Fune	eral C	hapel.	Inc	•	
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4		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ente	r the mode of dy	ing, such as cardiac	or respiratory a	rrest,	į	Approximate tnterval Between	
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Examiner		resulting in death)			CCI			Ì		_
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cords, P.O. Box 68760, requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-trensit	edical Examiner	Sequentially list conditions, if eny, leading to immediate	or as a consequ	ence of):						
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quire quire ould b	8					24a. Wes	an autopsy	av	ailable prior to	
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Division of Vital Records, P.O. B or Attending Physician: The law requires that the death effer death. Director: After this certificate has been signed by the atter in by the funerel director, page 2 should be detached for	Completed					1/4	Yes 2 200	1[∃Yes 2□ No	
Division of Vital Retorted to the Hospital or Attending Physician: The within 24 hours efter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	BeC	25. Was case referred to medical			26. Place of Deat	th (Check only	one)	1		_
of Vita Physician: this certific	0	examiner? 1 ☐ Yes % No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA O	ther:	ome 5□Res	idence 6 □Oth	er (Specif	(v)	
P P O	H	27. Menner of Deeth 28a. Date of Injury	28b. Time of	28c. Inju	ury at	28d. Describe	how injury occur	red		
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Division To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral preserves.	8	29a. Certifier Certifying Physician: To the best of my kn	owledge, deeth	occurred at the	time, date and plece,	and due to the	cause(s) and m	anner as s	tated.	
Ho Ho	edical	(Check only one) 2 ☐ Medicat Examiner: On the basis of examinant and manner steted.	ation end/or inve	estigation, in my	opinion, death occur	red et the time,	date and place,	and due to	tne cause(s)	
Vithin To th	ž	29b. Signature and title of certifier	200				_		-	
		00500	INID	D2	61061		Mar.	29,	2006	
6		30. Name and address of person who completed cause of deeth (Ite	m 23e) (Type, F	Print)						
5		Azeez Abiodun, M.D. 811	8 Good	Luck	Rd. Lanh	am, Mo	١.			
St	ate	31. Dete filed (Month, Day, Yeer) 32. Registrer's Sign	#### Armer Forces 1 1 2 2 2 2 2 2 2 2							
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DHMH 16 Rev 6/		to 2000 persone		Olivia:						

		1	For State Registrar	_	epartment of Health and M Certificate of Death	lental Hygiene	HUb I b J J
			T. Decement's Name (First, Middle, Las	<i>f</i>		2. Date of Death Month Day	3. Time of Death
	Physicia /Medic		Patricia N	erry		3 26	06 3:25 PM
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death	4c.	County of Death
			RIDERWOOD NURSING	G FACILITY	SILVER SPRING		ONTGOMERY
	Funeral		5. Social Security Number 6. Se	пи оЖе	Months Davs Hours Min.	8. Oate of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		290-20-0077	83 Y	rs.	DEC. 31, 1	922 CANNADA
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	/aryik	ŏ		DEMILE CI	2.4		1X Yes 2 □ No
	the A	ect	MARYLAND MONTGOME I 10e, Street and Number	RY BETHESI	JA 10f. Zip Code	10g. Citi	izen of What Country?
	with	Funeral Director	6015 HENNING ST.		20817	U.S	. A .
	Jeath	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
(0	r iter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	1 ☐ Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, etc.
93	ours a	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	TE Yes ZoLING Specify.		Specify: WHITE
2-0	72 hours after death with the Maryland insturel; or ttems 23e or 28e-f show digal Evantiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		Decedent's Usual Occupation (Give kind of work done during most of work	ing 16b. Ki	ind of Business/Industry
21	within ene. then "	npldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		
21	filed withi Hygiene. other then		12	DEN	NTAL RECEPTIONIST	DE e (First, Middle, Maiden	NTAL
pu	be fill htal H bd otl	Be	17. Father's Name (First, Middle, Last) PATRICK O'DONNELL	,	ANNE WRI	- ,	oumame)
2	2 should be f and Mental I Is marked of eumatic eve	2	19a. Informant's Name/Relationship (7		Mailing Address (Street and Number or Rur		or Town, State, Zip Code)
***	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I fleathth and Mental Hygiene after 1 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, I a Medical Evani ner must be notified at		KATHKEEN CULLITON	,,,,,	945 PICKERING DR. GE		
	Health Health tem 27 other tr	i di	20a. Method of Disposition	20b. Place of	Disposition (Name of		ocation - City or Town, State
Baltimore,	00		1 XBurial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	y, crematory or other place) REEK CEMETERY MARCH	30,06 WASH	INGTON D.C.
Ħ	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licen	·	22. Name and Address of Facility $J0$	All the Contract of the Contra	
Ba	permit. Departr Importe eny inju		William R	Bush	5130 WISCONSON AVE	N.W. WASHI	NGTON D.C. 20016
	_		23a. Part1. Enter the disease, or comp	plications that caused the death. Do n	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	AHOLOS COOLS	1 -1/ / V	CSC .	Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consequence of			2 6/11/0 3
	Examiner		O THE REAL PROPERTY.	b			
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):		
	nd nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c			
90,	ate be executed hysician and the burial-transit	E	resulting in death) cast	Due to (or as a consequence of	or);		
8760		dlcal	•	d			
9	requires that the death certifics een signed by the attending ph hould be detached for use as t	Me.	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	attenc for us	lan	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 24\(\subseteq \text{No} \)	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	1	Month Day Year
0	the s	Physician/Me	1 ☐ Yes 24 No 9 ☐ Unknown	9☐ Unknown	3 Gitter (specify)		
Δ.	that the death cer ed by the attendin detached for use	H.	Part II. Other significant conditions of	ontributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
Vital Records,	w requires that been signed be should be deta	Completed by				1 ☐ Yes 2	No 3 Probably 4 □Unknown
200	≥ □ ∞	lete				24a. Was an	24b. Were autopsy findings available
Re	yeicien: The law is certificate has b director, page 2 st	ш				autopsy performed?	prior to completion of cause of death? 1 \(\text{Yes} 2 \subseteq \text{No} \)
a	ificate or, pa		25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 € No th (Check only one)	10 163 2010
5	Physician: r this certific ral director,	To Be	examiner? 1 \(\text{Yes} \) \(\text{X} \) No	Hospital: 1 inpatient 2 ER/Ou	Other % 4	ome 5 Residence	6 ☐Other (Specify)
of	g = g		27. Manner of Death		Firme of 28c, Injury at Work?	28d. Describe how injur	ry occurred
ior	Attending r death. ector: After by the fune	atlo	1 Matural 5 ☐ Pending 2 ☐ Accidentinvestigation	n	M 1 Yes 2 No		
Division	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
ā	itel or rs aft rel Di						
	Hosp 4 hou Fune ely fil	edical	(Check only 2 Medical Exar	niner: On the basis of examination an	e, death occurred at the time, date and place d/or investigation, in my opinion, death occu-	, and due to the cause(s rred at the time, date and) and manner as stated. d place, and due to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	one) 29b_Signature.apd title of certifier.	and manner stated.	29c. License number	29d. Da	iter signed (Month, Day, Year)
	N T S		Weson allo	WHID	D0033475	3/	27/06
			20 Name and distance of the same of the sa	completed cause of death (Item 23a)			
	5		KAREN MERRIT, MD			MARVI AND	20904
	St	ate	31. Date filed (Month, Day, Year)	32. Abgistrar's Signature		PARILAND	40704
	Regist		MAR 3 0	2006 Brews S.	Sparke		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 5 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death RONALD HELMIG MÄRCH 27 2006 11:10 PM 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 13113 CHERRY BEND TERRACE GERMANTOWN MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 8. Date of Birth (Month, Day, OCT 28 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F Days 1937 BOLIVIA 215-86-6562 68 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 Yes 2 No MONTGOMERY GERMANTOWN 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 13113 CHERRY BEND TERRACE 20874 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ☐Yes 2☐No Yes, Give Specify SOUTH 1 Yes 2□ No Specify: WHITE If Yes, Give/ Year or Dates: 3 Widowed 4 Divorced ÁMERICAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ENGINEERING Elementary/Secondary (0-12) College (1-4or 5+) CIVIL ENGINEER ARCHITECTURE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WALTER HELMIG ZOILA ESPINOZA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20876 19a. Informant's Name/Relationship (Type, Print) SUIBEL SCHUPPNER/DAUGHTER 21325 VILLAGE GREEN CIR., GERMANTOWN, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ALL SOULS CEMETERY 3/29/06 4 □ Donation 5 □ Other (Specify) GERMANTOWN, MD 22. Name and Address of Facility
HILTON FUNERAL HOME 21. Signature P.O. BOX 86, BARNESVILLE, MD 20838 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12 months Immediate Cause (Final disease or condition LUNG CARCINOMA

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-fahow

Director

Completed by Funeral

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ir than "natural", or items 23a or 28a-f abov the Wedical Examiner must be notified at

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Pages 1 and 2 should be filed within 72 hours after

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Depertment of important: if any injury or once.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner burial-transit been signed by the should be detached Medical Certification: To Be Completed by certificate has I irector, page 2 s After the funeral within 24 hours efter To the Funeral Dira filled in t

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Due to (or as a consequence of):											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	hy, leading to immediate Due to (or as a consequence of): use (Disease or injury										
that initiated events resulting in death) Last	c. Due to (or as a consequence	of):									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3⊟Ectopio 5⊟ Other (23d. Date of de Month	olivery Day Year				
Part II. Dther significant conditions of	ontributing to death but not resulting	in the underlying	g cause given in Pa	art I.	23e. Did tobacco		o the cause of death robably 4 □Unkn				
)					24a. Was an autopsy performed?	death?	utopsy findings avail completion of cause s 2 No	lable of			
25. Was case referred to medical			26. Pl	lace of Death	(Check only one)						
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	utpatient 3	OOA Other: 4	Nursing Hor	me 5 Residence	6 ☐Other (Spe	ecify)				
27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2	- 2	28d. Describe how in						
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, in building, etc. (Specify)	farm, street, fact	ory, office		28f. Location (Street : City or Town, Sta	and Number or F ite)	Rural Route Number,				
	ysician: To the best of my knowledgeniner: On the basis of examination a and manner stated.										
29b. Signature and title of certifier			9c. License numb	er	29d. D	ate signed (Mon	th, Day, Year)				
1 Andrala	mym	on description of the control of the	D23308		3/	28/06					
30. Name and address of person who	empleted cause of death (Item 23a	(Type, Print)									

Registrar

State

31. Date filed (Month, Day, Year)

MAR 3 0 2006

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VICTOR PRIEGO, MD 6420 ROCKLEDGE DR., #4100, BETHESDA, MD 20817

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			For State Registrar	State of Marylan			nt of Hea <i>te of De</i>		1ental Hy	gieni Reg. No		U	11041	
	14 A) As	Decedent's Name (First, Middle, Las	it)					2. Date of De			Year	3. Time of Death	_
н	Physici /Medic		Ella Limmer	Homewood					April		2006	1841	3:27 p.m.	
	Examin	-	4a. Facility Name (If not institution, give	street and number)		4b. Cit	, Town, or Loc	ation of Death		40	. County	of Death	•	
		*	46005 Strickland					Mills			St	Ma		
	Funeral		Social Security Number 6. Security Number	M 2KTF		If Und Month:		Under 24 Hrs. lours Min.	8. Date of Bi	ay, Year		Coun		7
	Director		042-14-2115	86	Yrs.				Feb. 20	, 19	20	Conne	cticut	
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation						10	Od. Inside City Limits	;
	Aaryl • • • • •	ō	W 1 1 0 W	,		a	- W!11-						1 ☐ Yes 2X No)
	28a-	Director	Maryland St. Mai	y's			t Mills ip Code	3		10g. C	itizen of W	hat Coun	try?	_
	with Ba or			Dood			2063) /.		Uni	tod	State	. 6	
	ns 23	Funeral	46005 Strickland	12. Was Decedent Ever in U.	.S. 13.	Was Dec			ecify Yes or No Rican, etc.)		14. Race	- Americ	an Indian,	_
9	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Ifem 27 le marked other then "natural", or Itema 23a or 28a-f ehow other traumatic event, Ira Madical Exp., item river traumatic event, Ira Madical Exp., item river traumatic event.	Fun	1 ☐ Never Married 2 📉 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give		If Yes, sp 1 ☐ Yes		lexican, Pueπα ipecify:	Hican, etc.)		Specify	k, White,		
21215-0036	ral',	1 by	3 Widowed 4 Divorced	Year or Dates:		703	24,10							
ις Ο	72 h	ete	15. Decedent's Ed (Specify only highest gra		(Give	kind of v	ual Occupation ork done durin	n ng most of work	ing	16b. l	Kind of Bu	siness/Ind	iustry	
7	e filed within al Hygiene. I other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired) naker				0	n Hon		
	tygie thert		17. Father's Name (First, Middle, Last)			поше		Mother's Nam	e (First, Middle	, Maide			ile	
and	ould be i Mental I arked o	Be c	Fredrick Limmer					Unknov	.m					
Maryland	2 should be and Mental le marked aumatic ev	J.	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Addre	ss (Street and		vii ra <i>l Route Numt</i>	er, City	or Town,	State, Zip	Code)	_
<u>≅</u>	and 2 sealth ar n 27 le	ĺ	James Walter Home		46005	Str	ickland	l Road	Great	M i 11	s. M	arvla	and 20634	
ē,	Heal Hem 2 other		20a. Method of Disposition	20b. F	Place of Disposementery, cre	osition (A	ame of		Date			City or To		_
9	ages ent of nt: If i		1 Burial 2 XCremation 3 4 Donation 5 Other (Specific	Removal from State		-		e 4-5-	2006	Cha	rlot	to Ha	a11. MD	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other ance.		21. Signature of Funeral Service Licer										ne, P.A.	
ã	Depared Important		Kyle S. Sin	mons MO12	-								20650-027	19
68760,	Physician /Medical Examiner bulk sician and physician and physician and si the parial-Itansit	al Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	uence of):	Zas	Vic.	Card	Quove	lese	e o Pa	1)	Interval Between Onset and Death	
687		edical												_
.O. Box	The law requires that the death certifi tie has been signed by the attending I page 2 should be detached for use as	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknowh	23c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	ıl death 3	⊒Ectopic ⊒ Other	pregnancy specify)				23d. Dat Mo	te of delive	ery Day Year	
<u>α</u>	res that igned b be deta	by Pi	Part II. Other significant conditions of	contributing to death but not res	sulting in the I	underlying	cause given i	n Part I.	23e. Did	tobacco	use cont	ribute to th	ne cause of death?	
rds	w require been sig should b								1 🗆	Yes	2□No	3 Prob	ably 4 Unknown	1
Vital Records,		Completed							24a. Wa auto pen 1 ☐ Yes	s an opsy ormed? 2		Were auto prior to co death? I Yes	psy findings available mpletion of cause of No	8
/ita	Physician: 1 rthis certifical ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			Other		th (Check only					
ð	Physic this c	2	1 XYes 2 No	1 Inpatient 2	ER/Outpatie			4 Nursing H	ome 5 Res			er (Specif	y)	
	ding F h. After funer	lon	27. Manner of Death Natural 5 Pending Accident investigatio	28a. Date of Injury (Month, Day Year)	injury	М	28c. Injury at Work?	2 □ No	200. 0000100	11011 111	uly occur	100		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	9 200 Bloom of Injury - At h					28f. Location City or To	(Street a	and Numb ite)	er or Rura	il Route Number,	
	ne Hospita n 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my known inner: On the basis of examination and manner stated.	owledge, dea ation and/or i	th occurr nvestigati	ed at the time, on, in my opini	date and place on, death occu	, and due to the	e cause , date a	(s) and ma	anner as s and due to	tated. the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifier	/		:	9c. License n						Day, Year)	
			Mh	1 trus			024	285		4	7-	4-0	6.	
			30. Name and address of person who											
			William D. Boyd	II, M.D., 2536	5 Poin	t Lo	okout I	Road, L	eonardt	own.	Mar	y1and	20650	_
	St	ate	31. Date filed (Month Pay, Year) 2	32 Aegistrar's Sign	ature	ne est								

		For State Registrar	State of N	Marylar				lealth a		Re	g. No.	16	11642	
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, IAN BRUCE HEAT 4a. Facility Name (If not institution, Memorial	TLY	at E	aston	4b. City,	Town, or East	r Location of	of Death	2. Date of Death Month March	Day 8, 3		3. Time of Deat 1000	
Funeral Director		5. Social Security Number 137–24–5734			last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min.	8. Date of Birth (Month, Day, OCT 11,	Year) 1932	9. Birthp Court NEW	tace (State or Fore try) JERSEY	
ms 23a or 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD TA	ALBOT	10c. C	ity, Town or Lo							1	Od. Inside City Lin	
a or 28 be no	Dire	10e. Street and Number 28702 EDGEMER	תם ק			10f. Zip	Code	21601		10	og. Citizen of	What Cour	ntry?	
natural', or items 23a or 28a-f show dical Examinar mast by nutified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceder Armed Force	s? ∃No					igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	14. Ra	ce - Americ ick, White,		
/IDE	Completed	15. Decedent' (Specify only highes: Elementary/Secondary (0-12)		or 5+)	16a. Deced (Give life. I	dent's Usua kind of wo DO NOT us	rk done	during mos	st of working	g	16b. Kind of B	Business/Ind	dustry	
	Соп	12	5+	,	INTER	NATIO	NAL			(First 14 day) 1		NKING		
i i	To Be	17. Father's Name (First, Middle, L WALTER BRUCE H								(First, Middle, M RA ZENN		me)		
or other traumatic event, the M	-	19a. Informant's Name/Relationsh BARBARA Z. HEA	_							Route Number,	1000		Code)	
or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation		te	Place of Dispo cemetery, cren	nsition (Nar	me of other place	се)	Da	ate 2	20c. Location	- City or To		
any injury or of once.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	pecify)	СН	ESAPEAK	2. Name an	nd Addre	ss of Facilit	tv		STEVEN:			
5 8		JOHN R	. MERCI	ERO	$\stackrel{\mathbf{F}}{\sim}$	ELLOW	HAF	RELFER	N ST I	& NEWNA	MD 21	ERAL . 601	HOME PA	
hysician and the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or Due to (or d.	as a conse										
200000000000000000000000000000000000000	by Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 ☐ Fet tat time of	al death 3	Ectopic pi Other (sp		′				ate of delive	ary Day Year	
d be detached f	d by Ph	Part II. Other significant condition	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown				
rector, page 2 should t	Completed	METAITAIC PROSTATE CAR CINOMA 24a. Was an autopsy performed? 1 Yes 2 2 No 1 Yes								death?	psy findings availampletion of cause			
ector	Be	25. Was case referred to medical examiner?	Hospital:				Oth			eath Check only one				
After this funeral di	tion: To	1 Yes 2 No 27. Manne eath 1 atural 5 Pendin 2 Accident investig	28a. Date of li (Month,		28b. Time o Injury		28c. Injur Wor	4 🗆 NL	21	e 5 Reside 8d. Describe ho			y)	
ed in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State)							al Route Number,					
completely filled in t	edical	29a. Certifier 1 Certifyin (Check only 2 Medical I	g Physician: To the be Examiner: On the basis and manner	s of examin	nowledge, deat nation and/or in	h occurred vestigation	at the tir	me, date ar ppinion, dea	nd place, ar ath occurre	nd due to the ca d at the time, da	ause(s) and mate and place	nanner as s , and due to	tated. o the cause(s)	
	Me	29b. Signature and title of certifier 30. Name and address of persony	16,0	death (Ite	m 23a) (Type	20	c. Licens	3/4	66	29	9d. Date signo	ed (Month.	Day, Year)	
+VA Sta	ate	LUDWIG J. EGLS 31. Date filed (Month, Day, Year) MAR 3 1	EDER III, N		503 CYN		DR.,	, EAS	TON, 1	MD 2160	1			

Registrar

HUTCHINSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2 **Physician** Johnson M. dessie, 06 9:45 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SUBURBAN HOSPITAL **BETHESDA** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 ☐ M 2 🛛 F Yrs. JULY 31 1930 SOUTH CAROLINA Director 249-48-4032 75 Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits adical Examiner must be notified at 1X Yes 2 No Directo MD MONTGOMERY ROCKVILLE 10f. Zin Code 10g. Citizen of What Country? 10e, Street and Number 20852 U.S.A. 238 4607 OLDEN ROAD Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "natural', or Item eny injury or other traumetic event, the Madical Examiner 2002. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married BLACK Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSE KEEPER 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANNIE MAE JOHNSON UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4607 OLDEN ROAD ROCKVILLE, MARYLAND 20852 LINDA WITTER/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Murial 2 Cremation 3 Removal from State GATE OF HEAVEN 3/31/2006 SILVER SPRING, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Nosocomial pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 TUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Tyes 2 No Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Division 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: A d in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO D 0062167 3/25/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRATTS ROAD CLINTON, MARYLAND HOSSEIN AKHONDI-ASL M.D.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAR 3 0 2006

Johnson

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Registrar's Signature

			1 - For State Registrar	State of Maryland / Department of Health and I Certificate of Death	Mental Hygiene
	Physici	an	Depedent's Name (First, Middle, Las		2. Date of Death Month Day Year 7'50 A M
	/Medio Examin		4a. Fecility Name (If not institution, give	ore Jursing (Fr. Hyattsuille 7. Age (In.yrs) last birthday) If Under 1 Year II Under 24 Hrs.	8. Date of Birth (Month Dev, Year) 8. Date of Birth (Month Dev, Year) 9. Birthplace (State or Foreign (Country)
	Director works :	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	h with the 3e or 28a	al Direc	10e. Street and Number	a Rd.#3, y.w. 20001	10g. Citizen of What Country?
980	s I and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23e or 28a-f show other traumetic event, I'm Medical Examinar must be notilied at	Completed by Funeral Director	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Your Ustan in U.S. If Yes, specify Cuban, Mexican, Puert If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert I ☐ Yes 2 ☐ No Specify:	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	filed within 72 ho Hygiene. other then "natui	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	(Give kind of work done during most of work one during most one during most of work one during most of	er Private
Maryland	should be file and Mental Hy Is marked oth sumetic event	To Be (17. Father's Name (First, Middle, Last) Willie JAC	Kson, SR. Ann	
_	Pages 1 and 2 sho nent of Health and int: If Item 27 Is m iry or other traum		19a. Informant's Nama/Relationship (1) 20a. Meth of isposition 1 Buria 2 Cremation 3	Brother 14431 Innstruck (20b. Place of Disposition (Name of cometery, crematory or other place)	The state Number, City or Town, State, Zip Code) One Silver Spring MD 20906 Date 20c Location - City or Town, State
Baltimore,	permit. Pages Department of Important: If II eny injury or o		21. Signature of Funeral Service Licen		onnette +ASSOC. Funeral Home
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. SEPS15 Due to (or as a consequence of):	Cor respiratory arrest, Approximate Interval Between Onset and Death U.C.K.S.
8760,	ate be executed hysicien and ihe burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decease of Myley that initiated events resulting in death) Last	Due to (or as a consequence of): C	
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Δ.	quires that in signed b uld be deta	by	Part Other significant conditions co	intributing to death but not resulting in the underlying cause given in Part I. Hetastasis	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown
al Records,		Completed	End Stage	Kenal disease	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Vital	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	ath (Check only one)
of	Phys rr this aral di	To I	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at	tome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
Division	or Attending after death. Director: After in by the fune	Certification:	Natural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	281. Location (Street and Number or Rural Route Number, City or Town, State)
Ω	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Cer	29a. Certifier 1 Certifying Phyone) 2 Medicel Exam	rsician: To the best of my knowledge, death occurred at the time, date and place iner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	a, and due to the cause(s) and manner as stated. Irred at the time, date and place, and due to the cause(s)
	To th To th	Me	29b. Signature and title of certifier	R- Tuli 29c. License number D19609	29d. Date signed (Month, Dey, Year) Narch 29, 2006
4	1		3503 PERRY	ompleted cause of death (Item 23a) (Type, Print) RAMAN R. T. STREET, MT. RAINIER, MD &	1ULT, MD 20712
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrat Signal 6	

State of Maryland / Department of Health and Mental Hygiene 0

		•	State Registrar		Ce	rtificate of	Death	R	ag. No.		
		A	Decedent's Name (First, Middle, La.	st)				2. Date of Deat			3. Time of Death
8	Physicia		Bruce Eugen	e Jenkin	S			March	2 ^{Day}	2006	6:42 A M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death			unty of Death	J
	LXaiiiii		412 High St.	7.00	no (la use last histoday)		Windsor	8. Date of Birth		Carro	lace (State or Foreign
- P	Funeral Director		213-50-1019	9X 7. AG	99 (In yrs. last birthday) 54 Yrs.	Months Days	Hours Min.	Dec. 29,	1951	COUN	sylvania
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	e Maryl	ctor	Maryland Carro	11		New V	Vindsor				1 XYes 2 □ No
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: If term 27 is marked other than "naturel", or items 23a or 28a-f show important: If term 27 is marked other than "naturel", or items 23a or 28a-f show eny injury or other traumatic event, Tra Medical Examinar must be notified at once.	ai Director	10e. Street and Number 412 High St.			10f. Zip Code	21776	1		of What Coun	ntry?
	dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Span. Mexican, Puerto	pecify Yes or No-		Race - Americ Black, White,	
21215-0036	urs after el', or Its Examin	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☐XNo	Specify:	,			ite
5-0	72 ho natur	Completed by	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	king	16b. Kind o	of Business/Inc	dustry
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Maryland	ould be Mental arked o	To Be	Daniel H. Jenk					ty Frizz			
7	should and Men is marke	F	19a. Informant's Name/Relationship (19b. Maili	ing Address (Street				wn, State, Zip	Code)
	end 2 seelth ar m 27 ts her trau		Susan Jenkins/ wi	fe	412 H	ligh St.	Ne	w Windso	r, MD	21776	
ē,	f Hee f Hee Item othe	Ì	20a. Method of Disposition		20b. Place of Dispo	osition (Name of omatory or other place		Date	20c. Locati	on - City or To	wn, State
E	Pages nent of I		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		Sams Cree			2006 n	ır. Ma	rston,	MD
Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature of Foneral Service Lice	9° & last		2. Name and Addre		tzler Fu ew Winds			6
- 4			23a. Part1. Enter the disease, or com	plications that cause	d the death. Do not en						Approximate Interval Between
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. LUN	2 UAN	1 con					Onset and Death
	Examiner		1	Due to (or as	a consequence of):						
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S, P	ss theighed be det	ру Р	Part II. Other significant conditions	contributing to death t	out not resulting in the t	underlying cause giv	en in Part I.	23e. Did tol	bacco use o	contribute to th	ne cause of death?
Records,	w require been sig should t	ted						127	es 2□N	o 3 Prob	ably 4 Unknown
ecc	lawr as be	Completed						24a. Was a autops	sy	prior to cor	psy findings available mpletion of cause of
<u> </u>		Con						perform 1 ☐ Yes	med 2 No	death? 1 ☐ Yes	2□ No
Vital	clen: ertific	Be (25. Was case referred to medical examiner?					th (Check only on	ne)		
of \	Physicien: this certific ral director,	2	1 Yes 2 No	Hospital: 1 Inpati			4 Nuising n			Other (Specifi	y)
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_	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	aiC	29a. Certifier Cartifying Pl	nysician: To the best	of my knowledge, dea	th occurred at the til	me, date and place	, and due to the c	ause(s) and	d manner as s	tated.
	1 24 h	dic	(Check only 2 Medical Example)	minar: On the basis of and manner s	of examination and/or in tated.	nvestigation, in my o	pinion, death occu	rred at the time, d	late and pla	ice, and due to	the cause(s)
	To the To the Comp	X	29b. Signature and title of certifier			29c. Licens	se number	1	9d. Date si	gned (Month,	Day, Year)
	4		•			()(JW 5	1	5/0	17/0	M06
-	ML		30, Name and address of person who	completed cause of	death (Item 23a) (Type	, Print)	C L	1 301	11	,	11-21/54
	10		YOUSUV H. G	attar :	55 S.	Center	rStree	t Nes.	tmir	rster	IND 7
i de	Sta	te	31. Date filed (Month, Day, Year)	32 Regist	rar's Signature						

DHMH 17 Rev 1/2001

Registrar

MAR 3 0 2006

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended#8perFH FCHD, KS Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 11:01 A M William Emmett Johnson March 27 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | ff Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1**√2** M 2□ F Director Yrs. 578-60-0025 61 Washington, DC November 2, 1944 Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b, County 10d. Inside City Limits r than "natural", or itsma 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Maryland Frederick Frederick Direct 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6335 Mountaindale Rd. 21702 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after al Hygiene. other than "natural", or its 1 X Yes 2 ☐ No ff Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Police Officer permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 is marked other I any Injury or other traumatic event. In once. County Police Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Evelyn Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti K. Johnson / Wife 6335 Mountaindale Rd./ Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory April 2,06 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/ Frederick, MD Kaymond 23a. Part 1. Exter the disease, ox complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Macorosol FREARCTION /Medical Due to (or as a consequence of): Examiner OSONN PL ARTER if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical the as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peeu ERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? iphe-2 No 1750 1 Yes or Attending Physician: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation s after dec. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Att. within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MY 3.28.06 00060469 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) R. 400 West Seventh St./ Frederick, Maryland Yospin, Jeremy 31. Date filed (Month, Day, Year) MAR 3 1 State 1 2006 Registrar

			State of Maryland / D	epartment of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 6 1 6 4 9	8							
	g		Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Dea	ath							
	Physici:		Regina M. Johnston	Month Day Year March 24, 2006 8:10 p	М							
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death								
			Hillhaven Nursing Center, Inc.	Adelphi Prince George's								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min. (Month, Day, Year) Country)	reign							
	Director		Usual Residence of Decedent	Aug. 11, 1920 New York								
	ow ow		10a. State 10b. County 10c. City, Town	or Location 10d. Inside City Lin	imits							
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	th the or 28;	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?								
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	er deg	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.								
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2-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28a-f show ha Medical Espring frost Le notified at	ted	15. Decedent's Education 16a. I	ecedent's Usual Occupation 16b. Kind of Business/Industry								
212	hin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired) 16b. Kind of Business/Industry								
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Maryland	d ta b	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame) Blanche E. Carmody								
3	should be ind Mental marked o	70										
<u>a</u>	d 2 st th and 7 Is n traun		· · · · · · · · · · · · · · · · · · ·	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Bridge Street, St. Augustine, FL 32084								
	1 and Health tem 27			hisposition (Name of crematory or other place) April 3,								
OF.	Pages nent of int; If it ury or o		1 Xburiar 2 Cremation 3 Chemoval from State	Heaven Cemetery 2006 Silver Spring, Mary	land							
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins Funeral Home Inc								
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8760,	auth certificate be executed Wedical Attending physician and for use as the burial-transit	lical Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Foo to (or as a insequence of): d. Poo to (or as a insequence of): d. Poo to (or as a insequence of): d. Poo to (or as a insequence of): d. Poo to (or as a insequence of): d. Poo to (or as a insequence of):									
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rds, P	w requires that been signed should be de	ed by P	Part Other significent conditions contributing to death but not resulting in Dementiq	he underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 Tyes 2 No 3 Probably 4 Winking								
Il Records,		Completed by	Parkinson's Diseas	24a. Was an autopsy findings avail prior to completion of cause death? 1 \(\text{Yes} \) 2 \(\text{Vio} \) 1 \(\text{Yes} \) 2 \(\text{Vio} \) 1 \(\text{Yes} \) 2 \(\text{Vio} \) 1	lable e of							
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical	26. Place of Death (Check only one)								
of	Physi this c	To	1	UISTON								
uc	ding Phys h. After this tuneral dir	ion	1 Natural 5 Pending (Month, Day Year) In	ne of 28c. Injury at / 28d. Describe how injury occurred work? M 1 Yes 2 No								
Division	or Attend after death Director: /	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm									
2	al or / after I Dire d in b	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, State)								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Physicien: To the best of my knowledge. (Check only one) The dicel Exeminer: On the basis of examination and and manner stated.	death occurred at the time, date and place, and due to the cause(s) and manner as stated. or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
ı	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) 7 M 27, 200	6							
• •	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (1) 10 8 51. Date filed (Month, Pay, Year) 32 degistrar's Signature	Joseph Drive Silver Spring, MD 20	901							

7			1 10450			nd / Departm					-	DIC.		
SIX			1 - For State Registrar	State of Ma	ii yiai	Certific			u Menta		. No.	16	116	49
7	Physici	an	1. Decedent's Name (First, Middle, La			-				of Death			3. Time of	
	/Medic	al	Aaron C. Jeffe			145	City Town	a Lanation of D		ren 2	24°, 200		7:45	. Ам
	Examir	er	4a. Facility Name (If not institution, giv	e street and number)	10	Spice 40.		Location of De			2011		ore	
4	Funeral		5. Social Security Number 6. S		(In yrs.	last birthday) If U	nder 1 Year	If Under 24 H	Hrs. 8. Date	of Birth		9. Birtho	place (State o	or Foreign
4	Director		577–68–6217 Usual Residence of Decedent	™ 2□F		4 Yrs.	Luis Days	110013	May	14,	1951	Wash	ington	, DC
10	yland Now		10a. State 10b. County		10c. Ci	ty, Town or Location							10d. Inside Ci	ty Limits
Joffel	e Man Se-f sh	ctor	MD Prince	Georges	H	Iyattsvill	.e						1 XYes	2 🗆 No
a),	death with the Maryland ms 23a or 28s-f show croust be notified at	Funeral Director	10e. Street and Number 2400 Queens Chap	el Road #	115	10	Zip Code 20 7 8	32			g. Citizen of N Jnited		-	
_	r deat	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?		J.S. 13. Was D	ecedent of H specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes	or No-		e - Americk, White,	can Indian, etc.	
JEFFETSON	urs afte al', or II Examin	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo		es 🌠 No	Specify:			Specify	/ Bla	ck	
5-0	72 ho	Completed	15. Decedent's E			16a. Decedent's	Usual Occup	ation during most of d)	working	1	6b. Kind of B	usiness/In	dustry	
121	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5	+)			ive Cle:		I	Ioward	Univ	ersity	Hosp
102	filed I Hygid other	Be Co	17. Father's Name (First, Middle, Last,			<u> </u>		18. Mother's I	,		aiden Suman	1e)		_
Var	Menta Menta Mrked arked	To B	Leroy Jefferson						y Butl					
AARON JEFFERSO, Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28s-f show eny injury or other treumatic event, the Medical Examinet must be notified at once.		19a. Informant's Name/Relationship (Leroy Jefferson	Type, Print) Father		19b. Mailing Add	ress (Street Sham I	and Number of Place N	W Wash	Number, ingto	on, DC	2000 2000	Code)	
AARON altimore, M	of He of He or other		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □	Removal from State	20b. I	Place of Disposition cometery, crematory	(Name of or other place	ce)	Date 4 /1 /00	20	Oc. Location -			
† Hi	it. Pag riment riant: njury o		4 ☐Donation 5 ☐ Other (Specif	fy)	MC						Vashing	•		
Bal	Depa impo eny i		21. Signature of Funeral Service Lice	1500		22. KAU 38	stin 1 21 14	s of Facility Foyster th Stre	Funer et NW	al Ho Washi	me ngton.	. DC	20011	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the dea								Approximate Interval Bets	ween
	Physician		Immediate Cause (Final disease or condition	a Acquirod	Im		ficien		drome	_		i	Onset and I	
	/Medical Examiner		resulting in death)	Due to (or as	consec	quence of):		/ t						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consec	quence of):								
	ficate be executed physicien and is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consac	Tuence of):						_		
760,	sicien burial	calE		D000 (0) 035 (a consec	quence or).								
68				_ 0		-								
30X	eath certific ettending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome			eic pregnancy	/				te of delive	*	Year
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica r death. setor: Afler this certificate has been signed by the ettending ph by the funeral director, page 2 should be detached for use as th	Physician/Med	1 Yes 2 No	4 ☐ Pregnant at 9 ☐ Unknown	time of o	death 5 ☐ Othe	r (specity) _				1410		Day	i oai
م.	es that thighed by be detact	by Ph	Part II. Other significant conditions of	contributing to death bu	ıt not res	sulting in the underly	ng cause giv	en in Part I.	236	. Did toba	cco use cont	ribute to t	he cause of d	leath?
rds	w requires been sign should be	ted b							-	1 🗌 Yes	2 🗆 No	3 🗌 Prot	bably 4	Inknown
ecc	alawra asbe a2sh	Completed							248	. Was an autopsy		prior to co	opsy findings a	available ause of
al H	iclan: The law certificate has rector, page 2 (r							No	death? 1 🗌 Yes	2 No	
× ×	ysiclan: is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatient 3	DOA Oth	05	Death <i>(Ch</i> ecking Home 5			er (Specif	11 150	ice
o	ding Phys n. After this funeral di	n; T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	У	28b. Time of Injury	28c. Injur Wor				injury occur		" HOY	
sior	uttendir death. ctor: Af y the fur	catlo	2 Accident investigation 3 Suicide 6 Could not b	n		М	1 🗆	Yes 2 □ No						
Divi	tal or At is efter of al Direct ed in by	Certification;	4 Homicide determined	28e. Place of Inju building, etc		iome, farm, street, fa	ctory, office			ation (Stre or Town,		er or Rura	ai Route Num	ber,
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	hysician: To the best of miner: On the basis of and manner sta	examina	owledge, death occu ation and/or investiga	rred at the tir ation, in my o	ne, date and pl pinion, death o	ace, and due ccurred at the	to the cau	ise(s) and ma e and place,	nner as s and due t	tated. o the cause(s	()
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licens			290	d. Date signe	d (Month,	Day, Year)	
	_		- Z/Sols	>			77	24170		1	tarch :	4,2	006	
	5		30, Name and address of person who	hey Hospice	-	m 23a) (Type, Print) 3 P. N. Eu	taw S	+ B	altim	ore 1	10 2	420)1	
	Sta Registi		31. Date filed (Month, Pag Kear)	2006 32. Régistra	ar's Sign	ature for	W							

DHMH 17 Rev 1/2001

Registrar

	1 - For State Registrar		State of Ma	7	epartment of F Certificate of			Reg. No.	5 165
Physicia	1. Decedent's Name Mildre		st)	Jol	nnson		2. Date of De Month	Day	Year 3. Time of Death
/Medica	al Principle		street and number)	00,		r Location of Dea	March th	30 2006 4c. County o	5:35 P
Examine	Avalon Ma	70 - T			Hager	_		Washi	
Funeral	5. Social Security Nu	mber 6. S	ex 7. Ag	e (In yrs. last birth					Birthplace (State or Foreign Country)
Director	204-26-	9375	^{□м 2} Т 73	Y r	s. Says	110010	April 1		Pennsylvania
and	Usual Residence of 10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limits
the Marylar 28e-f show	j Maryland	Wash; ir	gton	Hager	stown				1 ☐ Yes 2 📉 No
or 28e	Maryland 10e. Street and Num	ber			10f. Zip Code			10g. Citizen of Wh	nat Country?
23a o	14014 Mars	sh Road			21740)		USA	
urs after des	11. Marital Status 1 Never Marrie 3 Widowed		12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedent of Hilf Yes, specify Cuba		Specify Yes or No rto Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
thin 72 hours e. "natural", Medical Exa	(Speci Elementary/Secor	15. Decedent's Ed fy only highest gra idary (0-12)	lucation de completed) College (1-4or 5		Decedent's Usual Occup Give kind of work done ife. DO NOT use retired	pation during most of we d)	orking	16b. Kind of Bus	
ed wi	5 12	5		De	ntal Assist		(Clark kalidala	Healt1	Care
e d fa b	17. Father's Name (_			Ottie		Maiden Surname)
should be nd Mental n marked o	Oquil 19a. Informant's Na	La Wesley		19b. N	Mailing Address (Street		Rebecc		tate. Zio Code)
INICA Did 2 s Lith an Lith an 27 is r trau		Johnson			14 Marsh Ro				,
s 1 ar if Hea item other	20a. Method of Disp	osition	· · · · · · · · · · · · · · · · · · ·	20b. Place of D	Disposition (Name of crematory or other place		Date		ity or Town, State
Pages nent of I	` 4 □ Donation	5 ☐ Other (Specify	Removal from State	Green	Hill Cemete	1	3/2006	Maynesboi	co, PA
permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other traumetic page.	21. Signature of Fur	neral Secreta Licer	Paul T. Ic	hstampfor	22. Name and Addre Lochsta pf 48 S. Chur	ess of Facility For Fune	ral Home	, Inc.	7268
	23a. Part1. Enter th	e disease, or com			t enter the mode of dyir	ng, such as cardia	ac or respirato, a	rrest,	Approximate Interval Between
Physician	Immediate Cause (I	Final	1	chsi	S will	to He	porter	Sun	Onset and Death
/Medical	resulting in death)		Du to (or as	a consequence of):	. ~ 0/7	Bica	2.00	
Examiner	_ Sequentially list con	ditions,	b. [7]	A STA	ge xei	cae i	1	CSE .	yeary
po is	Sequentially list con it any, leading to import cause. Enter Under Cause (Disease or i	tying	203 to Tot 88	a consequence of	40 8 M	ellit.	28.		Xoen e
xecut and al-trar	cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		c. Due to (or as	a consequence of):	1 2 1		2	70000
ficate be executed physician and is the burial-transit	<u> </u>	•	a Cere	620 C	as cu	WO (acec	don't	Xears
To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	IF FEMALE: 23b. Was decedent in the past 12 t 1 Yes 2 2 9 Unknown	nonths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	у		23d. Date Mont	of delivery h Day Year
quires that I		cant conditions	ontributing to death b	out not resulting in t	he underlying dause giv	ren in Part I:	123e. Did t		oute to the cause of death? B Probably 4 Unknown
The law require the law require the law been spage 2 should	Completed	of R	espi	rator	If Tro	of '	24a. Was autop perio 1 □ Yes	rmed?_ de	ere autopsy findings available for to completion of cause of arth? Yes 2 \sum No
stan:	25. Was case referr	d to medical	V				ath (Check only o	one)	
hysic this ce	O 1 ☐ Yes 2 ☑ 1		Hospital: 1 Inpatie		eatient 3 DOA	4 Aniursing		dence 6 Other	11777
ling P	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tir y Year) Inj	ury Wor	ryat rk? Yes 2 ∐No	28d. Describe	how injury occurred	1
ttand death death stor: ,	2 Accident	investigation		urv - At home, farn	n, street, factory, office	143 5 140	28f. Location (Street and Number	or Rural Route Number,
after Direction by	27. Manner of Death 1 Deathral 2 Accident 3 Suivi é 4 Homicid	determined	building, et	c. (Specify)	The state of the s		City or To	wn, State)	
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	29a. Certifier			f examination and	death occurred at the tir or investigation, in my o				
To th Within To th comp	29b. Signature and	title of certifier	10/11/	MAD	29c. Licens	se number			(Month, Day, Year)
	100	all	900	1000.	20	0450	3/	March	(30 2006,
6	30. Name and addre	ess of person who	completed cause of c	leath (Item 23a) (T	ype, Print) PL	Hag	reest	own	230 2006, MD21742,
Stat Registra			32. Registr	rar's Signature	Coole				

			1 - For State Registrar	State of Marylan		artment of F		d Men		ene	6	11652
3 3	3,8		Decedent's Name (First, Middle, Last)						ate of Death			3. Time of Death
8.7	Physici /Medic		Donna Bernice	Kresal				1	Month arch	Day 28, 200	Year)6	8:15 A ^M
	Examin		4a. Facility Name (If not institution, give s.	treet and number)		4b. City, Town, o	r Location of D			4c. County		0.13 11
*			20308 Jefferson Bl	vd.		Hagerst	own			Wash	ingt	on
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days			ate of Birth Month, Day,	(ear)	9. Birthpl Count	ace (State or Foreign
-3	Director		464-48-1181	64	Yrs.				pt. 9,		Iowa	
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10	Dd. Inside City Limits
	danyi 1 sho	ច	Maryland Washingto									1 ☐ Yes 2 X No
	the t	Director	10e. Street and Number)11	пад	10f. Zip Code			100	g. Citizen of W	hat Count	try?
	3a or	۵	20308 Jefferson Bl	vd.		21742				United		•
	be filed within 72 hours after death with the Maryland nat Hygiene. Id other then "natural", or items 23s or 28s-1 show event. The Medical Examinar must be mailfied at	Funeral	11. Marital Status	2. Was Decedent Ever in U.	S. 13. V	Was Decedent of H	lispanic Origin'	? (Specify '	Yes or No-		- America	
ထ	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1,83Yes 2 □ No 196	0-	f Yes, specify Cuba	an, Mexican, Pi	uerto Ricar	n, etc.)		c, White, e	etc.
00	raf', c	by	3 ₩Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	961	1□Yes 2XXNo	Specify:			Specify:	Wh	ite
5-0	72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Giva	dent's Usual Occup	during most of	working	11	Sb. Kind of Bu	siness/Ind	ustry
2	ithin Me	idir	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired emaker	4)	,		0		
7	e filed within al Hygiene. I other then vent, the Me		12 17. Father's Name (First, Middle, Last)		110111	emakei	10 14-45	Mana (Fin		Own 1		
anc	d fa b	Be	Donald Tener							a <i>iden S</i> u <i>m</i> ame	9)	
Ž	2 should be and Mental is marked o	ဥ	19a. Informant's Name/Relationship (Type	no Briet)	106 14-111-	ng Address (Street			penine		04-1- 71	0-4-1
Z	end 2 s ealth an m 27 is:		Donald Kresal / Son			Lee High						
ē,	ges 1 end 2 should t of Health and Men if item 27 is marke or other treumstic	- 3	20a. Method of Disposition					rch 3		Oc. Location - (
OL.	permit. Pages 1 end 2 Department of Health a important: if item 27 is eny injury or other tre ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Restl	sition (Name of natory or other place naven Gardens	[⊝] ¦ Ma	irch 3 2006			- 1 3/	1
Baltimore, Maryland 21215-0036	nit. F partmo ortar injur		21. Signatur			. Name and Addre .esthaven						laryland
ä	Depariment Department Impo		> M1/		9	estnaven 501 Cato	runera tin Mt	ıı Ser	Vices,	, Skkot derick	Cody	y P.A. 21701
4.2			23a. Part . Enter the disease, or complice shock, or heart fallure. List only on	cations that caused the death								Approximate Interval Between
₽.	Physician		Immediate Cause (Final disease or condition		nh	Strong	Bul	Mil-	mon	1) 10	264	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):	0,00	(-)		
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	st sd	Examiner	l any, leading to the rediate cause. Enter Underlying Cause (Disease or injury	Dua to (or se s concequ	uarita of):							
	and i-tran	xarr	that initiated events resulting in death) Last	. Due to (or as a consequ	uence of):						-	
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687	icate phys s the	dical	d									
) XO	leeth certific attending p I for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregna	ncy					22d Date	of delive	n.
$\mathbf{\alpha}$	deeth atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnancy Other (specify)	'			Mon		Day Year
o.	the the	Physician/Me	9 Unknown	9□ Unknown								
۳,	The law requires that ste hes been signed b sage 2 should be deta	by P	Part II. Other significant conditions con-	tributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	:	23e. Did toba	cco use contri	bute to the	e cause of death?
Records,	w require been sig should b	edt						_	1 PYes	2 🗆 No	3 🗌 Proba	ably 4 Unknown
900	e law re hes bec ge 2 sho	piet						1	24a. Was an	24b. W	Vere autop	sy findings available
ď	The i	Completed						_ ,	autopsy perform Yes 2	ed? d	eath?	pletion of cause of 2 □ No
ita	Physician: 1 this certifical al director, p	Be	25. Was case referred to medical examiner?				26. Place of		eck only one			
>	S S	2	1 Yes 2 No H	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursin	ng Home	5 Aesiden	ce 6 Othe	r (Specify)
n c		ü	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k?	28d. I	Describe hov	injury occurre	ed	
sio	Attending r death. ector: Attel	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No					
Division of Vital	in Dir	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str V)	eet, factory, office		28t. L	ocation (Stre City or Town,	et and Numbe State)	er or Rural	Route Number,
1	Hospital 24 hours a Funeral I stely filled		29a. Certifier 1 Certifying Phys	icien: To the best of my kno	wledge death	a necurred at the tra	ne date and a	lace and d	lue to the co	100(0) 0=1 = -		atod
	To the Hospital within 24 hours of To the Funeral I completely filled	edlcai	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death o	occurred at	the time, dat	e and place, a	nd due to	the cause(s)
	To the h within 24 To the F	Me	29b. Signature and title of certifier	2		29c. Licens	e number		296	d. Date signed	(Month, I	Day, Year)
	M		1			17	175	4-7		3/2	8/00	
11	OFIVE		30. Name and address of person who con	mpleted cause of death (Item	1 23a) (Type,	Print)				//		
1	Λ,		William F. Harper,	M.D. 180 Th	omas J	ohnson Di	cive, S	te. 1	01, Fr	ederic	k, MI	21701
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 200	32. degistrar's Signa	ture	ant a						
150	registi	पा	MILITY - T COL		-	CONTRACTOR OF THE PARTY OF THE						

			For State Registrer	State of Mar		artment of H rtificate of I			ene) () () g. No.	11653
I	Physici /Medic		1. Decedent's Name (First, Middle, Last) Blake Aaron KNOTT					2. Date of Death Month	Day Y	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s Shady Grove Advent		tal	4b. City, Town, or	Location of Deal	th	4c. County of	
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days				Birthplace (State or Foreign Country) Maryland
21215	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "neturel", or lieme 23e or 23e-f show an marked other than "neturel", or lieme 23e or 23e-f show aumelic event. It a Madical Examiner must be notified a	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washing to the street and Number 17414 Apple Blosso 11. Marital Status **E Never Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 0	om Court 2. Was Decedent Ev. Armed Forces? 1 Yes, Give Year or Dates:	16a. Dece (Give		Specify: ation during most of wo	40 Specify Yes or No- to Rican, etc.)		American Indian, White, etc. white
and	id be filed ental Hygi ked other ic event, II	Be	17. Father's Name (First, Middle, Last) Aaron Knott					me (First, Middle, M y Reynard	aiden Sumame)	
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	Physici		1. Decedent's Name (First, Middle, Last							2. Date of Dea	ath Day	Year	3. Time of Death
	/Medio		Perrie Nelson 4a. Facility Name (If not institution, give	Lee, Sr.		4b. City,	Town, or	Location of		March 1		ounty of Death	10:30 M
, y	_ Xuiiii		Millennium Health	& Rehabilita	tion	Fore	estvi	ille			Pri	nce Ge	orge
	Funeral Director		5. Social Security Number 6. Se 218-24-2370 Usual Residence of Decedent	7. Age (In yrs. 80	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da Aug. 13	v. Year)	9. Birth Cou 5 Mary	place (State or Foreign intry) y Land
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "naturei", or Iteme 23a or 28e-f ehow eny lajury or other treumatic event, the Medical Examinant or other treumatic event, the Medical Examinant or other treumatic event, the Medical Examinant or other treumatic event, the Medical Examinant or other treumatic event, the Medical Examinant or other treumatic event, the Medical Examinant or other treumatic event, the Medical Examinant or other treumatic event, the Medical Examinant or other treumatic event, the Medical Examinant or other treumatic event.	To Be Completed by Funeral Director	10a. State 10b. County Maryland Prince G 10e. Street and Number 2818 Viceroy Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grade) 12 17. Father's Name (First, Middle, Last) William H. Lee 19a. Informant's Name/Relationship (T) Perrie N. Lee, Jr 20a. Method of Disposition	eorges Di 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates: cation e completed) College (1-4or 5+) rpe, Print) / Son	16a. Dece (Give life. I Supe	Heig 101. Zip 20 Was Deceder If Yes, spect If Yes, spec	O Code 0747 Jent of Hickory Cubar 2 No al Decupark done dise retired; O T (Street a	Specify: Ition uring most 18. Mother Mary and Number Ave. (of workings of workings of workings of summer of summer or summer	cify Yes or No Rican, etc.)	USA 14 Sp 16b. Kind Pri Maiden Sc 1 ghts,	n of What Cou Race - Ameri Black, White, pecify: Blace of Business/Ir nting Imame)	can Indian, etc. ck Industry Service o Code) 0743
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E. 2	Physicia		Decedent's Name (First, HAROLD	Middle, Lasi		MARSHA	LL		·		2. Date of De Month MARCH		Year 2006	3. Time of Death	_
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	and		Usual Residence of Deced	ent	'	10c. City	, Town or Lo	cation						10d. Inside City Limits	
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			Registrar 1. Decedent's Name (First, Middle, Last)		rinicate of L		2. Date of Death	J. No: 0 0 0	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or	Location of Death		4c. County of Death	1
			Casey House		Rockville	e		Montgomer	
	Funeral		. M⊓M 2□E	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign intry)
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	or 28g	irec	10e. Street and Number		10f. Zip Code		100	. Citizen of What Cou	intry?
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	teme	ne	11. Marital Status 12. Was Decede Armed Force	s?	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Spen, Mexican, Puerto	acify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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yla	Men Marke Matic	ဥ	Herbert McClellan McCormic			Joan Laur			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene. Depar		19a. Informant's Name/Relationship (Type, Print) Dolores L. McCormick/wife		_			City or Town, State, Zi burg, MD 2	
ē,	Heal Heal tem 2		20a. Method of Disposition		osition (Name of matory or other place			c. Location - City or T	
ē	Pages ent of nt: If i		1 ☐ Burial 2 【②Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	18	matory or other place ke Cremato	1	-	eltsville,	Marvland
Baltimore,	mit. F porter / injui		21. Signalura of Funeral Service Licensee					e P.O. Bo	
m	9 5 5 8		Devel & Houte	MO1251 B	everly L.	Heckrott	e, P.A.	Clarksvill	e, MD 21029
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ed the death. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	atic Non Sm	all Cell I	Lung Canc	er		Onset and Death
	/Medical Examiner			as a consequence of):					
		-	Sequentially list conditions, b	as a consequence of).					
	uted 1 Insit	Examiner	cause. Enter Underlying Cause (Disease or injury						
ó	exection and rial-tra	Еха	that initiated events c. Due to (or a	as a consequence of):					
8760,	ate be executed hysicien and the burial-transit	Ical	d.						
39)	ntifica ing pt	Med	IF FEMALE:	***					
Box 6	aath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3	Ectopic pregnancy			23d. Date of delive	ery Day Year
	Attending Physicien: The law requires that the death certificate be executed redeath or death. The flaw requires that the certificate has been signed by the attending physicien and ector. After this certificate has been signed by the funeral director, paga 2 should be detached for use as the burial-transit	Physician/Med	1 Yes 2 No 4 Pregnant 9 Unknown 9 Unknown		Other (specify)				
0.0	res that t signed by I be detac		Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	quires n sign	d by					1 🗆 Yes	2√2No 3∏Pro	bably 4 Unknown
00	s been si	Completed					24a. Was an	24b. Were aut	opsy findings available
æ	The la	L o					autopsy performe	prior to co death? XNo 1 ☐ Yes	ompletion of cause of 2 No
ita	ctor, i	ВеС	25. Was case referred to medical examiner?			26. Place of Death			
<u>></u>	hysic this co	ို	1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpa			4 Nuising Ho		ce 6 K Other (Spec	hy)Hospice
2 UC	r Attending Physician: The laver death. rector: After this certificate has by the funeral director, page 2	lon:	27. Manner of Death 1 Natural 5 Pending (Month, I	njury 28b. Time o Da <i>y</i> Year) Injury	Work'	at ? 'es 2 □ No	28d. Describe how	injury occurred	
Division of Vital Records,	death death ctor: y tha	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of	Injury - At home, farm, str			281 Location (Stre	et and Number or Rui	al Route Number
<u> </u>	efter Direction	Certification:	4 Homicide determined 200. Flace of building,	etc. (Specify)	out, ractory, office		City or Town,	State)	,
	To the Hospital or Attentwithin 24 hours effer deatl To the Funeral Director: completely filled in by tha		29a. Certifier 1 Cartifying Physician: To the be (Check only 2 Medical Examinar: On the basis	st of my knowledge, deat	h occurred at the time	e, date and place,	and due to the cau	se(s) and manner as	stated.
	the H hin 24 the F	Medical	and manner	stated.					
	5 N Will		29b. Signature and title ol certifier		29c. License			I. Date signed (Month	
			30. Name and address of perso o leted cause of	f death (Item 22a) (Trees	D42452	۷	ма	rch 29, 20	00
0)	22			l Muncaster	,	Rockvil1	e, MD 20	855	
	Sta		31. Date filed (Month, Day, Year) 32. Refi	strar's Signature					
	Registr	ar	MAR 3 1 2006	in the parties of	men				

			1 - For State Registrar	State of Marylar		artment c		ר		Reg. No.	06	11658
	Physici	an	Decedent's Name (First, Middle, Last,						2. Date of Dea Month	Dav	Year	3. Time of Death
	/Medic		RAPHAEL SANTI	MASCAROTTI					March	22	2006	6:30 P M
	Examir	er	4a. Facility Name (If not institution, give		ntor		vn, or Location				ounty of Death	r 37
_			Brook Grove Nursi 5. Social Security Number 6. Se			If Under 1 Y	ly Spri		8. Date of Birt			
	Funeral Director			M 2□F 84	Yrs.	Months D	ays Hours	Min.	8. Date of Birt (Month, Da July 30	y, Year) 192	1 Monad	place (State or Foreign atry)
	ש		Usual Residence of Decedent	10.0								
	ehov	<u>ا</u>	10a. State 10b. County Maryland Montgome		andy S						'	0d. Inside City Limits 1 Yes 2 No
	28a-f	ect	10e. Street and Number	-		10f. Zip Co	de			10a. Citize	n of What Cour	
	3a or	by Funeral Director	18100 Slade School	1 Road		208				U.S		, .
	death The 2	nera	11. Maritaí Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent	of Hispanic O	rigin? (Spec	cify Yes or No	- 14.	Race - Americ	
9	or its	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 🔀			noari, otc.)		Black, White, Bec <i>ify:</i> Whit	
8	within 72 hours efter death with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow the Medical Exercia er mart be notified at	d b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:							of Business/In	
5	in 72	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	dent's Usual O kind of work o DO NOT use r	tone during mo	st of workin	ng .		ces of	dustry
77	r ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Dinn	ing Roo	m Capta	ain		Hote1	- Rest	aurant
힏	at Hyg	Bec	17. Father's Name (First, Middle, Last)				18. Moth		(First, Middle,	Maiden Su	ımame)	
<u>ya</u>	Ment Ment arked	To	Joseph Mascarot						ariani			
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other then "natural", or iteme 23a or 28a-f ehow mining or other treumatic event, the Medical Examinar must be notified at ancie.		19a. Informant's Name/Relationship (T) Pedro Marenco/Fri			-					iown, State, Zip ia 2271	
	1 end Health em 27 ther t		20a. Method of Disposition	and the same of		osition (Name in matory or other			ate V.		tion - City or To	
5	ages int of t: # it		1 ☐ Burial 2 🖺 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	TOTAL TOTAL STATE	cemetery, cre Linco	$natory or other 1n \mathtt{Cre}$	matory	3/28/	2006		-	Maryland
Baltimore,	artme ortan injur		21. Signature of Funeral Service Licents		2	2. Name and A	ddress of Faci	ility HIN	ES-RINA			HOME INC.
B	Depar Impor eny in		Nama A.	-	1	1800 Ne	w Hamp	shire	Ave, S	Silver	Spring	g, MD 20904
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Coronary Ar Due to (or as a conse	tery D:		f dying, such a	is cardiac or	r respiratory ai	rrest,		Approximate Interval Between Onset and Death 10 years
8760,	be executed cien and purial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension Due to (or as a consect Due to (or as a consect d.	quence of).							
P.O. Box 68	death certific e attending p od for use as i	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	af death 3	⊒Ectopic prøgr ⊒ Other (specr				230	d. Date of delive Month	ery Day Year
Ś	quires that in signed build be det	by	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying caus	e given in Parl	t I.				he cause of death? bably 4Unknown
Vital Record	ding Physicien: The law requires that the h. h. After this certificate has been signed by th funeral director, page 2 should be delach	Completed							24a. Was autor perfo	rmed?	death?	opsy findings available mpletion of cause of 2 No
ita	strifica ctor, I	Bec	25. Was case referred to medical examiner?					ce of Death	(Check only o	one)		
× ×	Physician: this certifican al director, i	2	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐	1						Other (Special	(y)
n c	ing P	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c.	Injury at Work?		8d. Describe	how injury o	occurred	
Division of	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm st		1 Yes 2 [28f. Location (Street and i	Number or Rura	al Route Number,
<u>≤</u>	i Site	ertli	4 ☐ Homicide determined	building, etc. (Speci	ify)				City or To			
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		rsician: To the best of my kn iner: On the basis of examin and manner stated.								
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. L	icense number	г		29d. Date :	signed (Month,	Day, Year)
			> Weten	is mg.		,-	D319	18		3/3	24/06	
	4		30. Name and address of person who c	ompleted cause of death (Ite), 3305 North	m 23a) (Type Leisu)	Print) re Worl	d Blvd	., Sil	ver Sp			
4	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 9 2	32. Registrar's Sign	nature	parte		_				

			1 - State of Maryland / Department of Health and Certificate of Death	d Menta	I Hygier	. U U O	11659							
	Physici	an	1. Decedent's Name (First, Middle, Last) John Kevin McMahon	Moi	e of Death		3. Time of Death 5:48 P. M							
	/Medi Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De			c. County of Death								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F	drs 0 Dot	e of Birth	Montgomes	lane (Chair and Consider							
L	Director		Usual Residence of Decedent	Feb	19,	1923 _{Washi}	ington, D.C							
	Marylan -f show fled ut	tor	10a. State			1	0d. Inside City Limits 1 Yes 2 □ No							
	th with the 23e or 28e	ai Director	10e. Street and Number 10f. Zip Code 20906			Citizen of What Cour Nited Stat	•							
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show may jury or other traumatic event. Its Medical Example 1 willed at ADGE.	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give WW II 1 Yes 2 X No Specify:	(Specify Ye Jerto Rican, e	s or No- etc.)	14. Race - Americ Black, White, Specify: Whi	etc.							
Maryland 21215-0036	hin 72 hou e. an "natura Medical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	working		Kind of Business/In								
d 21	filed wil Hygiend other the	e Con	Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First,		S. Post	Office							
ylan	ould be Mental narked c	To Be	James Patrick McMahon Ellen	Eli:	zabeth	Smith								
	and 2 shealth and 27 is near traun		19a. Informant's Name/Relationship (Type, Print) Michael McMahon/Brother 19b. Mailing Address (Street and Number or 14578 Outrigger Driv	re, Sai	Number, City 1 Lean	or Town, State, Zip Bro, CA 94	Code) 577							
Baltimore,	Pages 1 ament of He tant: If Item jury or oth	,	20a. Method of Disposition 1	ch 28 2006	Was	Location - City or To shington,	D.C.							
Ball	Departiment Departiment Important Im		21 Signature of Funeral Service License 22. Name and Address of Facility C P.O Box 58007	columb:										
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death							
A	Physician /Medical Examiner		a. ATHEROSCLEROTIC CARDIOUASCUAR DISCUSS SYEARS Due to (or as a consequence of):											
		ner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury)											
,	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
68760	ficate be physicials to the bur	edicai	d											
.O. Box (ath cert	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of delive Month	ory Day Year							
<u> </u>	w requires that the de been signed by the a should be detached t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236		use contribute to the	e cause of death?							
Vital Records,	The law recate has bee page 2 sho	Completed		_	was an autopsy performed?	prior to con death?	psy findings available impletion of cause of							
	s certific	To Be (25. Was case referred to medical examiner? 26. Place of D		on one	6 ☐Other (Specifi	4							
o uc	ding Phy D. After thi funeral o		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?		scribe how inj		7							
Division of	al or Attending Phy after death. I Director: After this d in by the funeral c	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Street a or Town, Sta	and Number or Rura te)	l Route Number,							
L	Hospita 24 hours Funera etely fille	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate and plate of examination and/or investigation, in my opinion, death occurred at the time, date and plate of examination and/or investigation, in my opinion, death occurred at the time, date and plate of examination and/or investigation, in my opinion, death occurred at the time, date and plate of examination and/or investigation, in my opinion, death occurred at the time, date and plate of examination and/or investigation.	courred at the	time date a	nd place, and due to	the caucale)							
	To the Hos To the Fur completely	Me	29b. Signature and title of certifier 29c. License number		29d. D	ate signed (Month,	Day, Year)							
	(8)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3365 N	LE!	SUPE	WORLD	8, 2000							
	Sta	to.	JAMES A. ROSSI M.D. S-11 VER	SPRI	14,	40 20	706							
	Registi		MAR 3 0 2006											

			a light was a second was	artment of Health and Mertificate of Death	ental Hygie Reg 2. Date of Death	ene 006	1 6 6 0	
	Physici /Medio Examin	cal	Harry Ellsworth MIMNALL 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Month 03	Day Year 27 06 4c. County of Death	110 4	
	Funeral		18005 Oak Ridge Drive 5. Social Security Number	Months Days Hours Min	8. Date of Birth (Month, Day, Y	Washington 9. Birthplac Country 1025 Panns	ce (State or Foreign	
	Director me 23a or 28a-f ehow minut be notified at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Washington Hagersto	ocation	May 24,	Pennšylvania 10d. Inside City Limits 1 □Yes 2Ž No		
	th with the 23a or 28a	al Director	10e. Street and Number 18005 Oak Ridge Drive	10f. Zip Code 21740	10g	U.S.A.	?	
	hin 72 hours after death with the Marylan e. m. natural; or Iteme 23e or 28e-f ehow Medical Examiner muni be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Not Midwed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Not Married 2 Not Married 12 Not Married 13 Not Married 14 Not Married 14 Not Married 15 Not Married	Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Black, White, etc Specify: Whit	λ.	
. 12.13-0030	within 72 ho ene. then "natur the wedical	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) Cotlege (1-4or 5+)	edent's Usual Occupation a kind of work done during most of workin DO NOT use retired) DETVISION	g	b. Kind of Business/Indus		
אומווא ב	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) Paul Brill Mimnall	18. Mother's Name	(First, Middle, Ma			
C, Prei	t and 2 sho Health and I Im 27 ie mu		Candace Winer - daughter 1850	ing Address (Street and Number or Rural Chancery Court, (Olney, Ma	aryland 208	332	
Daltillo	nit. Pages ' partment of h cortant: If its injury or ot		4 Donation 5 Other (Specify) Rest Have		h 31,	c.Location - City or Towr agerstown,N eral Home		
Š	Dermit Depart Import any in			15 East Wilson Blv	d., Hage	rstown, Mary	pproximate	
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í	w requires that the death certificate been signed by the ettending phys should be detached for use as the	by Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Da	ay Year	
1 (25)	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the c	cause of death?	
ב	e a se se se se se se se se se se se se se	Completed			24a. Was an autopsy performe	24b. Were autopsy prior to comp death?	letion of cause of	
DIVISION OF VIEW	To the Hospital or Attending Physician: The within 24 hours after death. To the Funarel Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at 2. Work? M 1 \(\triangle \text{Yes} \) 2 \(\triangle \text{No} \)	Residence	ee 6 □Other (Specify) injury occurred st and Number or Rural R	Outo Number	
2	spital or A nours after nerel Direc filled in by		4 Homicide building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge dea	th occurred at the time, date and place, a	City or Town, S	State)	ard	
	Fo the Ho within 24 I Fo the Fu completely	Medical	(Check only one) 2 Medicat Exeminer: On the basis of examination and/or in and manner stated. 29b. Signature and title of certifier	vestigation, in my opinion, death occurre-	d at the time, date	and place, and due to the Date signed (Month, Da	e cause(s)	
)			30. Name and address of person who completed cause of death (Item 23a) (Type	D0047234		3/29/06		
H.	-10+1		Name and address of person who completed cause of death (nem 23a) (Type Nell'i Strauss no 13424 Pennsy / Ua 31. Date filed (Month, Day, Year) 32. Registrar's Signature		town 1	NO 2174:	2	
	Sta Registr		MAR 3 1 2006	nerth				

	•	State of Maryland / Department of Health and 1- State Registrar Certificate of Death	d Mental H	lygiene Reg No	006	11661
Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Month	Day	y Year	3. Time of Death
/Medica		William McKinley Morgan		h 25,	. County of Death	3:10 P ^M
Examine	er	4a. Facility Name (If not institution, give street and number) Anne Arundel medical center 4b. City, Town, or Location of D Annapolis	ван		Anne Aru	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 I	Hrs. 8. Date of (Month,	Birth	9 Birth	place (State or Foreign
Director		226-62-2940 59	7–1	Day, Year) 1-194	6 Vir	ginia
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
r death with the Maryland ame 23s or 28s-f ehow ir must be notified at	ğ	Maryland Anne Arundel Annapolis				1 X Yes 2 □ No
r 28a	rec	10e. Street and Number 10f. Zip Code		10g. Cit	tizen of What Cou	intry?
th with	a D	1112 Lake Heron Dr., Apt. PB 21403			USA	
ig 8	by Funeral Director	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No 1 □ Yes 2 □ No	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: M	
5-003	ed b	3 Widowed 4 Divorced Year or Dates: 1964–66 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. K	ind of Business/l	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygene. It is marked other then "natural; or traumatic event. Its Medical Exert traumatic event.	Completed	(Specify only highest grade completed) (Give kind of work done during most of life, DO NOT use retired)	working	100.11		,
nd 2121 e filed within al Hygiene. tother then	E	College (1-4or 5+) 2 years Grocery manager		G	rocery S	tore
und 21215-0 be filed within 72 h tal Hygiene. ad other then "nature.	Be		Name (First, Mid	dle, Maiden	Sumame)	
Maryland 2 should be to and Mental is marked o	ို	Carrol Morgan	Sadie		Morgan	
Mar 12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of				Section 1
there		Katherine A. Morgan/ Wife 1112 Lake Heron Dr., 20a. Method of Disposition (Name of	Apt. P.	20c. L	Napolis, ocation - City or 1	MD 21403 Town, State
Pages nent of int: if its		1 Burial 2X Cremation 3 Removal from State	29-06	Fda	ewater,	MD
		4 Definition 8 Definition				ral Home
Bafti permit. Deportr Importe any inte		White Ellie 2973 Solomons Is	_			
66 be	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End Stage Chronic Contract Due to (or as a consequence of): Lypertension Due to for as a consequence of): TOBACCO Abuse	failur	e	1 Direce	15 year 40 year
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 1 Ves 2 No 9 Unknown 5 Other (specify) 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No 1 Ves 2 No Nown 1 Ves 2 No Nown 1 Ves 2 No Nown 1 Ves 2 No Nown 1 Ves Nown Nown 1 Ves Nown Now		-	23d. Date of deli- Month	very Day Year
dS, P.	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. D	id tobacco	use confribute to	the cause of death?
cords		Hirory of alcohol abuse	_ 1	Yes 2	□ No 3 □ Pro	bably 4 Unknown
Vital Reco	Completed	, 0	24a. W ai pi 1 □ Ye	utopsy erformed?	prior to death?	topsy findings available completion of cause of 22 No
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on of ding Phys. h. After this funeral di	tlon: To	1 Yes 2 No Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Virier: 4 Nursir 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Accident Response of Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Virier: 4 Nursir 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	ng Home 5 ☐ R 28d. Descri			cify)
Division at or Attending at fer death. I Director: After d in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Locatio City or	n (Street ar Town, State	nd Number or Ru e)	ral Route Number,
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai C	29a. Certifier (Check only one) 1. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and p 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	occurred at the tir	ne, date an	d place, and due	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Da	ate signed (Monti	n, Day, Year)
		D31977		3	12+10	76
		29b. Signature and title of certifier 29c. License number D3 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AND NEW GOLDON MD 2003 McClec 21 Parkway 5/10 31. Date filed (Month, Day, Year) 32. Pygistrar's Signature	O ANNO	pois	MD 2.	1401
Sta Registra		31. Date filed (Month, Day, Year) 32. Projistrar's Signature				

State of Maryland / Department of Health and Mental Hygiene State
Registramend Item #5 Per FH C854 4/20/06 JHCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Month **Physician** 1, ANNA MATURO April 1:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Hospice House Denton Caroline If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 8, 1915 9. Birthplace (State or Foreign Country) New York OSZ OP OOOZ 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖫 F 91 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-f ehow the Medical Examinar must be notified at 1 Yes 2 No Caroline Federalsburg Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3640 Pepper Road 21632 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No δ Specify: White 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent; if Item 27 is marked other projury or other treumatic event 9028. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cosmo Mitrano Jenny Petrucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3640 Pepper Rd., Federalsburg, MD 21632 Anthony Maturo/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ty☐Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐Other (Specify) Charles Cem. 4/08/06 Farmingdale, NY 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Can years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ed by the attending physicien end detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by this certificate has been significate has been signification, page 2 should be 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ဥ 3 No 1 🗌 Yes 3□ DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred Certification: 1 Natural 5 Pending 2 Accident investigation М 1 Tes 2 No in by the Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To una within 24 hours To the Funerel Directory Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cai (Check only one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number HOU47522 April 3 nd. 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Appiott, M.D. 5304 Federal Shurs 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 9 Str. Carle

			1 - For State Registrar	State of Marylar		artment of Health ar	nd Mental H	ygiene ()	06	11663	3
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	the Hospital hin 24 hours a the Funerel I npletely filled	edical	29a. Certifier (Check only 2 Medical Examination)	sicien: To the best of my kn ner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at the time, date and postigation, in my opinion, death	place, and due to the occurred at the time	e cause(s) and r e, date and place	nanner as si e, and due to	tated. the cause(s)	
	within To the Comp	ž	29b. Signature and title of certifier			29c. License number		29d. Date sign		Day, Year)	
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			30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type,	Print) Print Dr. Sts 7	Selisbun	Mg 218	01		
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month Arthur Edwin NYE Jr. March 29, 2006 9:45 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 17423 Amber Drive Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea, Jan. 24, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F 219-20-0456 77 1929 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17423 Amber Drive 21740 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12foreman organ manufacturer other 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event pops. 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Edwin Nye Sr. Gladys Evelyn Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou Jean Nye - wife 17423 Amber Drive, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 4/3/2006 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 23. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 years Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): physicien and s the buriel-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0. ete has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes : After this certification and funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No Certification: To 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury within 24 hours efter death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person no completed cause of death (Item 23a) (Type, Print) Mary C 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 31 Registrar

ORIGINAL

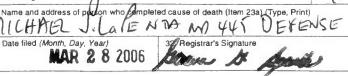
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 世 03 30 M **Physician** HELMA NOWOTTNICK ZAVE 03 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 25 E Yrs. 85 May 8, Director 218-16-2585 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itema 23a or 28a-f ehow the Mudical Expression that he natified at 1 ☐ Yes 2√√No Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1198 Patuxent Road 21113 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: Specify þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "na any injury or other traumatic event, the Madic one. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Isabelle Clark Joseph Duke Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 582 West Court, Glen Burnie, MD 21061 Mary Warnick (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-28-2006 Glen Burnie, MD Glen Haven Cemetery 22. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Funeral Service Licensee atril 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PART ETAL **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a con sequence of) Examiner The law requires that the death certificate be executed physicien and s the burial-transit esulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the ettending | | for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) signed by the et id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2□ No To the Hospitel or Attending Physician: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 1721438 M W

State Registrar

MAR 2 8 2006

31. Date filed (Month, Day, Year)



HIGHWAY

Bernard Nelson 06-2226 AKG

Please Type or Print in Black Indelible Ink

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ate of Maryland / Donartment of Health and	Montal Hygiana O. O. C.	11000
e of Print in black indelible ink. Ensure	All Copies are Legible.	

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or iteme 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director; After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

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	Decedent's Name (First, Middle, Last)					ate of Death	lav Yaar	3. Time of Death				
in al	Bernard Edwa	ard Nels	on		Ma	arch 31	, 2006 ear	1:52 P M				
er	4a. Fecility Name (If not institution, give s Saint Mary's Hospi			City, Town, or Location of conardtown	ic. County of Dead Saint Mai							
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٥	41973 Satchel Pai	ine Way	1	20636			United	•				
nera		12, Was Decedent Ever in U	.S. 13. Was [Decedent of Hispanic Origin, specify Cuban, Mexican,	n? (Specify	Yes or No-	14. Race - Ame	nican Indian,				
Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 【XNo Specify:			i, etc.)	Black, Whit	e, etc. lack				
eted	15. Decedent's Educ (Specify only highest grade		16a. Decedent's	Usual Occupation	of working	16b.	Kind of Business/	Industry				
mpik	Elementary/Secondary (0-12)	College (1-4or 5+)	1	of work done during most of OT use retired)	•		_					
Š	7 17. Father's Name (First, Middle, Last)		La La	aborer 18 Mother	s Name /Fire	st, Middle, Maide		truction				
9 Be							en samanie)					
2	Joseph A. Nelson 19a. Informant's Name/Relationship (Type	oe. Print)	19b. Mailing Add	dress (Street and Number	arah Si		or Town State	Zin Code)				
	Cheryl Barnette No		1	itchel Paige								
	20a. Method of Disposition	20b. F	Place of Disposition	(Name of	Date		Location - City or					
- 3	1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specity)	emoval from State	een of Pe		-7-200	6 He	len, Mar	vland				
- 1	21. Signature Tuperal Service Coense			ne and Address of Facility								
	Edward N. Brinsfie	ld, Jr. M000	52 22955	Hollywood H	Road,	Leonard	town, MD	20650-0279				
	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat e cause on each line.	h. Do not enter the	mode of dying, such as ca	ardiac or rest	piratory arrest,		Approximate Interval Between				
	Immediate Cause (Final disease or condition	allero	clustic	Careliano	ela 1	Diene	v.	Onset and Death				
	resulting in death)	Due to (or as a conseq										
<u></u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
n in	Cause (Diseese or injury	Duo to (or as a conseq	uonos on).									
Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):									
edicai	L _a											
edi												
an/k	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete		pic pregnancy			23d. Date of del					
by Physician/M	1 Yes 2 No	4 ☐ Pregnant at time of d 9 ☐ Unknown		er (specify)			Month	Day Year				
F.	Part II. Other significant conditions con	tributing to death but not res	ulting in the underly	ring cause green in Part I		23e Did tobacco	urea contributa to	the cause of death?				
d b			anny in the anadily	ang occoo given ar act.				obably 4 🛣 Unknown				
Completed						24a. Was an						
ш					_ '	autopsy performed?	prior to death?	topsy findings available completion of cause of				
	25. Was case referred to medical			26 Plane o	1 Dooth Ch	Yes 2 N	lo 1/2 Yes	2□ No				
To Be	examiner?	ospital: 1 ☐ Inpatient 20	ER/Outpatient 30	Othor			6 □Other (Spe	cify)				
L.	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		Describe how in						
atic	2 Accident investigation	,, 22, 132,	M		0							
Ħ H	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, street, fa	actory, office	28f. L	ocation (Street a	and Number or Ru ite)	ıral Route Number,				
Ce	20.0.4											
Medical Certification:	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☑ Medical Examin	ser: On the best of my known and manner stated.	wledge, death occu tion and/or investig	urred at the time, date and ation, in my opinion, death	place, and di occurred at	ue to the cause(the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)				
Σ	29b. Signature and title of certifier	. 11		29c. License number			ate signed (Mont					
	Throda le	, Kinga	~	O.C.M.E.		Ap	ril 1, 2	UUb				
	30. Name and address of person who con	mplited cause of death (Iten			D_1±	imare 7	Marar 1 1	01.201				
	TESOCRE Miking	20 1		Penn Street,	, balt	ımore, I	maryLand	21201				
е	31. Date filed (Month APP R ear) 5 /2	006 32. Pargistrar's Signa	ture des	ds s								

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 10:47 PM 03-27-2006 Ε. MARY O'NETLL 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Montgomery Takoma Park WASHINGTON ADVENTIST HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Phil., PA 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2√2√F 10-03-1915 90 160-09-2006 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 1K Yes 2 No Bowie Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20721 1116 King Street Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify: Black 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Industry Seamstress 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Robinson Emma Robinson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 962 Stable Ct. Davidsonville, Md. 21035 Joseph J. O'Neill/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 103-31-2006 Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 20746 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cedar Hill FH Inc. 4111 Penn., Ave. Suitland, Md. Mary Lyman MOI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Therosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

r than "natural", or Items 23a or 28a-f ehow The Madical Examiner must be notified at

Funeral Director

Be Completed by

ဥ

with the Maryland

filed within 72 hours after death

Hygiene.

other

permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked oth any injury or other traumatic event sone.

Baltimore, Maryland 21215-0036

physicien and s the burial-transit as the be detached i

Examine Physician/Medical þ Completed Be 은

Certification;

The law requires that the death certificate be executed ettending for use as the has Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

Records, P.O. Box 68760,

Division of Vital

9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an autopsy perform 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ormed? 2 0 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural м 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe

camar

19609

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman R. Tuli, MD 7600 Carroll Avenue Takoma Park, Maryland 20912

31. Date liled (Month, Day, Year) MAR 3 0 2006

32. Registrar's Signatur

State

Registrar

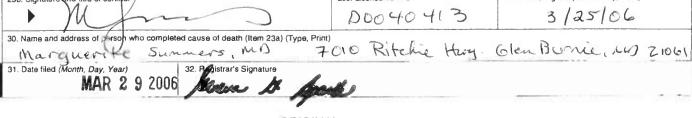
		1	For State Registrar	State of Marylar		artment of H		and Mental Hy	/giene Reg. No.	06	1668
			I. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia		Robert Vincent	Owens				APR	16	2006	5:00A M
	/Medic Examin		a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	r Location of	of Death	4c. Co	unty of Death	, ,
			Lorien Q. Ru	verside		De	KAM	P		MARI	red
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs		Months Days	If Under Hours	Min. 8. Date of B	irth bay, Year) 5, 194	9. Birth	place (State or Foreign htry) CUCKY
	Director		402-54-8809	M 2□F 65	113.	L		reb. 1	J, 174	i item	Lucky
and	A =	-	Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
Mary	d sh india	ō	MD Harf	ord	Aberde	en					1 ☐ Yes 🎢 No
the the	286	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Cou	ntry?
with	3a or	D	3452 Churchvill	e Road		21	001		U.	S.A.	
death	ms 2	Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Ori an, Mexicar	igin? (Specify Yes or N n, Puerto Rican, etc.)	lo- 14.	Race - Ameri Black, White	
6 after	or Ite	/Fu	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 ☐ No		1☐ Yes 2⊠ No	Specify:			oecify: Whi	to
1215-0036 within 72 hours after death with the Maryland	ital Hygiene. od other than "neturel", or liems 23a or 28e-f show event, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Dates: V1CL		edent's Usual Occup	ation			of Business/Ir	
721	net	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	e kind of work done DO NOT use retired	during mos	t of working	TOD. TURIS	01 24311.03411	dastry
with ir	than than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		Service			U.S.	Governi	ment
d 2	Hygi ther nt, I		17. Father's Name (First, Middle, Last)		OTVII	502,110	18. Moth	er's Name (First, Midd	le, Maiden Su	ımame)	
a p	Mental arked o	To Be	Elmer Owens				N	orma G. Pr	im		
Maryland 21215-0036	and Mental Is marked of reumetic ev	-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mail	ing Address (Street	and Numb	er or Rural Route Num	ber, City or T	own, State, Zi	ip Code)
Z pu	alth a		Rodney E. Owens	(Son)	103	2 Thomas	Rd.	Glen Bu			060
Je ja	item item		20a. Method of Disposition		cemetery, cre	osition (Name of ematory or other pla	сө)	Date		tion - City or T	
mo Page	ont: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	R.		ris & Co.	i	4/11/06		Cheste	r, PA
Baltimore,	Department of Health and Ments Importent: If item 27 is marked eny injury or othar treumelic e <u>2019</u> .		21. Signature of Funeral Service Licens	insusper	2	Z. Name and Addre Tarring—C Aberdeen,	argo Mary	Funeral Ho land 2100	me, P. 1-3399	A.	
	- 3		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the de	ath. Do not er	nter the mode of dyin	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between
PI	nysician		Immediate Cause (Final	On other	v Xx Yz	Panone	at c	concer			Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):	10001	aire	Control			*
E	xaminer		Sequentially lies conditions	/	oner	eatic c	ame	N			Tyear
	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	equence of):						,
V ecute	and	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	acuanca of):						
Records, P.O. Box 68760, <	ohysician and the burial-transit			282 (0 (0) 43 4 50)(3	545 5(155 51).						
8760,	physics s the b	Physician/Medical		d							
X 6	ding se as	/Me	IF FEMALE:	3c. If yes, outcome of preg	nancy				23	d. Date of deli	very
Box	attending ph	clan	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time o	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		_	Month	Day Year
O. E	ed by the detached	ysl	1 Yes 2 No 9 Unknown	9□ Unknown							
D \$	igned b	by Pt	Part II. Other significant conditions co	ntributing to death but not r	esulting in the	underlying cause gr	ven in Part	I. 23e. Di	d tobacco use	ontribute to	the cause of death?
rds	n sign		Imhan	dist dite	ine				□Yes 2□	No 3□ Pro	obably 4 Unknown
Records,	s been signal	Completed						24a. W	as an itopsy	24b. Were au	topsy findings available completion of cause of
Re 3	ie has age 2 (mo						pe 1 □ Ye	rformed?	death?	2□ No
	certificate rector, pag	BeC	25. Was case referred to medical				26. Plac	ce of Death Check on	one		
of Vita	this ce	70 E	examiner? 1 ☐ Yes 2 (\$25)o	Hospital: 1 Inpatient 2	☐ ER/Outpati	ent 3 DOA	and the second	ursing Home 5 R			cify)
	After th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time Injury	We			e how injury	occurred	
vision	eath. or: A	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2		o (Street and	Number or Ri	ıral Route Number,
Division	fter d Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t nome, tarm, s ecify)	street, factory, office)	City or	Town, State)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	2	29a. Certifier 1 Certifying Phy	sicien: To the best of my l	nowledge de	ath occurred at the t	ime, date a	and place, and due to t	he cause(s) a	and manner as	stated.
2	within 24 hours a virtual to the Funeral completely filled	edical	(Check only 2 Medical Exem	iner: On the basis of exam and manner stated.	ination and/or	investigation, in my	opinion, de	eath occurred at the tin	ne, date and p	lace, and due	to the cause(s)
4	ithin o the omple	Me	29b. Signature and title of certifier			29c. Licer	se number		29d. Date	signed (Monta	h, Day, Year)
•	- ≤ 1→ ŏ		DT 10.	MMy 11	111	02	2012	5	4	16/01	6
	~ 1	1	30. Name and address of person who o	ompleted cause of death (I	tem 23a) (Typ	e, Print)		, , ,		t	
	101		naus 1	necline in	0	In Ancie	Mail	pd Bu	Hun	mno	22014
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Si	gnature	perly		8	4		
	Regist	trar	APR 1 2 20	08 /	Nº M						

hysicia	ın	1. Decedent's Name (First, A. William	liddle, Last)		Pric	e	-	2. Date of D Month March		006 Year	3. Time of Death 7:22 PM
/Medic Examin		4a. Facility Name (If not instituted Washington A			1	4b. City, Town, or Takoma	Location of Death		4c. C	ounty of Death	n
uneral rector		5. Social Security Number 577-52-5331	6. Sex XX M 2□		yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	Q Rint	nplece (State or Foreig unity) Virginia
a-r snow iffierd at	ctor	Usual Residence of Deceder 10a. State 10b. Co DC	·		c. City, Town or Lo						10d. Inside City Limit
3a or 28 st.be no	Funeral Director	10e. Street and Number 219 Nichols	on Street	NE		10f. Zip Code 2001	1			on of What Co	•
tien z.f. is marked other train matural, or tems zea or zea-t show other traumatic event, the Modical Exp. where must be notified at	Ď	11. Marital Status XXNever Married 2□ 3 □ Widowed 4 □ Divo	Married Arme	Decedent Ever ed Forces? Yes 2 No s. Give or Dates:	1930-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Si n, Mexican, Puert Specify:	pecify Yes or N Rican, etc.)		. Race - Amer Black, White pecify: B1	rican Indian, e, etc. .ack
he Medical	Completed	15. Dece (Specify only h Elementary/Secondary (0-	dent's Education ghest grade comple (2) Colle	eted) ge (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired eral Home	during most of wor. 1)			of Business/l	
atic event, i	To Be Co	17. Father's Name (First, Mic Alfred Price	2				18. Mother's Nam Dorothy		e, Maiden Si	umame)	
ry or other traum	-	19a. Informant's Name/Relation Gerald Price 20a. Method of Disposition 1Å Burial 2 □ Cremation 14 □ Donation 5 □ Oth	(Brothe	er)	0b. Place of Disponentery, cre-	10th Ave sition (Name of matory or other place coln Ceme	. Takoma	Park,	MD 20 20c. Loca		Fown, State
any injury or other		21. Signature of Funeral Ser	vice Liceosea			2. Name and Addres				neral	
ician dical niner	ilner	23a. Part1. The the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tany Joseph Linderlying cause. Enter Underlying Cause (Disease or injury	aa	e to (or as a co	ury	Em bo		or respiratory a	arrest,		Approximate Interval Balween Onset and Death
ne burial-transit	cal Exa	that initiated events resulting in death) Last	c/s	cnal e to (or as a co Penal	nsequence of):	lure Ura				L	Mhum
detached for use as the L	Physician/Medi	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1	s, outcome of pr ive birth 2 Pregnant at time Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			236	d. Date of delivership	very Day Year
peq	Ď	Part II. Other significant cor	ditions contributing	to death but no	ot resulting in the u	nderlying cause give	en in Part I.		tobacco use		the cause of death?
haye a	Completed							24a. Was auto perf 1 🗆 Yes		24b. Were aut prior to c death? 1 \(\sum Yes	topsy findings available ompletion of cause of 2 No
lirector, page 2 s	Be	25. Was case referred to me examiner?	Hoenital	4.51	•FISSIO	Other	26. Place of Dea				
funeral o	atlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe 2 Accident	28a. [1 ∐ Inpatient Date of Injury Month, Day Yea	2 EP/Outpaties 28b. Time o Injury	f 28c. Injun	4 Nursing H	ome 5 ☐ Res 28d. Describe			ify)
ed in by the	Certification:			Place of Injury - building, etc. (S	At home, farm, stipecify)	reet, factory, office		28f. Location (City or To	(Street and I wn, State)	Number or Rui	ral Route Number,
completely filled in b	Medical	(Check only 2 Med one)		o the best of my he basis of exa manner stated.	y knowledge, deat mination and/or in	vestigation, in my or	oinion, death occur	and due to the red at the time.	, date and pl	ace, and due	to the cause(s)
· 5	2	29b. Signature and title of ce	11/11/	To .			803		3/24	Z XX	
-		30. Name and address of per	son who completed	cause of death	(Item 23a) (Type,	Print) Are	Takema	Park	mp		

State Registrar DHMH 17 Rev 1/2001

			For State Registrar	State of Marylan	d / Depa		lealth and M	lental Hyg	1311			
	Physici /Medic		1. Decedent's Name (First, Middle, Last Jacquelir	ne Plummer				2. Date of Dea Month Mar.	Day	3. Time of Death 1:55p M		
)	Examir		4a. Facility Name (If not institution, give Baltimore-Washi 5. Social Security Number 6. Se	ngton Med. x 7. Age (In yrs.		_	r Location of Death n Burnie If Under 24 Hrs. Hours Min.	8. Date of Birtl		of Death ne Arundel 9. Birthplace (State or Foreign Country)		
	Director		212-34-4916 15 Usual Residence of Decedent	^{3M 2} M ^F 66	Yrs.		Tiours IVIII.	Aug. 16	1939	PA		
	a-f show	ctor	MD 10b. County Anne Ar		y, Town or Lo	Glen Burn	ie			10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	th with the 23a or 28	al Director	10e. Street and Number 6642 Whitmore Co	ourt, #171		10f. Zip Code 2	1061		10g. Citizen of W	/hat Country? JSA		
036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examinat roust be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 22 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blac Specify	e - American Indian, k, White, etc. : White		
215-0	hin 72 ho a. an "natur Madical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work d)	ing	16b. Kind of Bu Ft. Mea	ade		
ind 21;	be filed with that Hyglene dother the	Be	12 17. Father's Name (First, Middle, Last) Matthew Orbany		Pe	rsonal Se		Post Chaplain ame (First, Middle, Maiden Sumame) Tate				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Madical Examinat roust be notified at 205e.	J.	19a. Informant's Name/Relationship (T) Karen L. West/Ni				and Number or Run Road, Sev	al Route Numbe		State, Zip Code) 21146		
			20a. Method of Disposition 1 □ Burial 2 🖺 Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,	Removal from State	emetery, cre	osition (Name of matory or other place rematory		28,	20c. Location Baltimo	City or Town, State		
Balti	permit. Depentre Importa any inju		21. Signature of Funeral Service Licent	Bulan						k Funeral Home k, MD 21146		
125	Pnysician /Medical		238. Pa 1. er the disease, or composition of the disease or composition edited C use (Final isease or of indition resulting in death)	distributions that caused the death of the cause on each line. a. Chronic O Due to (or as a consequence)	bstruc				rest,	Approximate Interval Between Onset and Death		
	Examiner	Jer	Sequentially list conditions, if any, leading to innectiate cause. Enter Underlying Cause (Disease or injury	b. Smoking Due to (or as a consequence)						20 years		
,092	te be executed ysicien and te burial-transit	cal Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	uence of):							
.O. Box 68	death certifica e attending ph ed for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregnation of the state of the st	,		23d. Dat Moi	e of delivery hth Day Year				
٥.	es tha	Ď	Part II. Other significant conditions of Breast Cancer		-	ınderlying cause gıv		1		ibute to the cause of death? 3 Probably 4 Unknown		
of Vital Records,	The law requir cate has been si page 2 should	Completed							rmed?	Were autopsy findings available prior to completion of cause of leath? Yes 2 \[\] No		
Vita	sician	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outnatie	nt 3⊠ DOA Ott	26. Place of Deat		ne) dence 6 □Oth	er (Specify)		
	Hing After Tune	atlon: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injur			now injury occurr			
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office		28f. Location (: City or Tox		er or Rural Route Number,		
	ne Hospital 124 hours (1 10 Funeral 16tely filled	Medical (ysician: To the best of my knowiner: On the basis of examination and manner stated.								
	To the I within 2. To the I	Me	29b. Signature and title of certifier			29c. Licens	se number			(Month. Day, Year)		

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 27, Day 2006 Year **Physician** Donald Lincoln Posey 4:27 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6612 Bucknell Rd. Bryans Road Charles If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1X M 2□ F Director 220-16-7224 May 27,1928 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23e or 28e-f show treumatic event. The Modical Examiner must be nutilised at 1 ☐ Yes 2 X No Maryland Director Charles Bryans Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6612 Bucknell Road 20616 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 DYes 2 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black þ If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Oscar Posev Nellie Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other tre Deborah Posey Thomas Daughter 6612 Bucknell Rd., Bryans Road, Md. 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ∰Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery, 2006 * 4 □ Donation 5 □ Other (Specify) Cheltenham, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 s I the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the dise shock, or heart failur se, or complications that cau List only one ause on eac Approximate Interval Between Onset and Death Immediate Cau e (Findisease or condition resulting in death) Longeshive **Physician** Heast /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Causa (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? certificate 2 No 1 Yes Hospitel or Attending Physiclen: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ 📆 Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury 1. Watural 1 Yes 2 No investigation 2 □ Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1— eartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

31. Date liled (Month)

701

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2006

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			1 - For State Registrar	State o	f Marylar	-	artmen rtificat			and M	lental Hyg	giene leg. No.) 6	11672	
	Physici	an	Decedent's Name (First, Middle, Harry	W. Parize	a r						Date of Dea Month	Day	Year	3. Time of Death	
	/Medio	cal	4a. Facility Name (If not institution,				dh Cih	Town 00	Location of	- A Donath	March	27,	2006 ty of Death	2:50 P.M	
	Examir	ier	Montgomery Ger	-				1ney		Death			ntgome	erv	
9	Funeral			6. Sex	7. Age (In yrs.	. last birthday)	If Under Months	1 Year	If Under		8. Date of Birth	1		lace (State or Foreign	
The state of	Director		049-01-4524	1☐M 2☐F		92 Yrs.	Months	Days	Hours	Min.	Sept. 1	, 1913	Conr	necticut	
	and		Usual Residence of Decedent 10a, State 10b. County	.	10c. C	ity, Town or Lo	ocation						11	0d. Inside City Limits	
	Maryl f sho	ō	Maryland Monte	omery		ilver	Caria	œ					1 ☐ Yes 2 ☐ No		
	r 28a	irec	Maryland Montg 10e. Street and Number	Omery		TIVEL	10f. Zip					10g. Citizen of	f What Coun	itry?	
	th wit	Funeral Director	15310 Pine Orch	ard Drive	e, # 1H	I .	2	0906				U.	S. A.		
	or dea	uner	11. Marital Status	Armed Fo		J.S. 13.	Was Deced	dent of Hi cify Cuba	spanic Ori	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bl	ace - Americ ack, White,		
36	d within 72 hours after death with the Maryland jiene. r then "netural", or Items 23a or 28a-f show The Madical Examer must be recilled at	by Fi	1 ☐ Never Married 2 [X] Marrie 3 ☐ Widowed 4 ☐ Divorced	nd 1 □ Yes If Yes, Giv Year or D	9		1 🗆 Yes					Spec	ity: Whi	ite	
21215-0036	72 hou	Completed	15. Decedent'	Education		16a. Dece	dent's Usu	al Occupa	ation	A = 4		16b. Kind of	Business/Inc	dustry	
215	within 7 ene. then "n	npie	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT u	rk done d se retired	<i>luring</i> mos)	t or worki	ng				
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Maryland	₽ la p >	Be	17. Father's Name (First, Middle, L David Parizer	ast)							e (First, Middle, e Hartzm		ime)		
Ž	d 2 should the and Ment to the and Ment to the market traumatic of the angle of the	Ţ	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	na Address	(Street a					n State Zin	Code) 20906	
	122 7 15 17		Miriam R. Pari		fe .									oring, MD.	
re,	of Health item 27 other tr	18	20a. Method of Disposition	. 107	20b.	Place of Dispo cemetery, crei	sition (Nar	ne of	a)	C	Date	20c. Location	- City or To	wn, State	
E	Page nent c		1 Burial 2 Cremation 4 Donation 5 Other (Sp		State					3/29	/2006	Falls	Church	n, Virginia	
Baltimore,	permit. Pages 1 Department of H Important: If ite ony injury or ot		21. Signature of Funeral Service L	icensee		22 F.	a. Name ar	Addres	s of Facilit	y inera	ıl Direc	tion.	Inc.		
	40 E 5 8	1	Vonald (.	Stott	tenye	1	∩01 R	ocky	1110	Pike	Rocky	1110		and 20852	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that confused on e	aused the dea ach line				g, such as	cardiac o	or respiratory arr	rest,		Approximate Interval Between Onset and Death	
2.0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ACI	JTE		CAR	DIAL	- 1	UFA	extral	<u></u>		HOURS	
	Examiner			b. ATHE	or as a consec		-02.11	h.	1000	~~	DISGAS	6	,	VEA DE	
31.	* 1	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consec		exam	Re 1	Mell	. /\	0126342			ICA:G	
	ate be executed hysicien and the burial-transit	Examiner	that initiated events	с											
ó,	e exe ien ar urial-t		resulting in death) Last	Due to (or as a consec	quence of):									
8760,	icate b physic s the b	dicai	1.1	d											
Box 6	death certificate e ettending phys d for use as the	Physician/Med	IF FEMALE:	23c. If yes, out	come of pregn	ancy						2015			
Bo	eath etten for u	cian	23b. Was decedent pregnant in the past 12 months?	1☐Live b	inth 2 ☐ Feta	al death 3	Ectopic pr						ate of delive lonth	ry Day Year	
P.O.	that the de led by the e detached t	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno											
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	s contributing to de	eath but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use cor	ntribute to th	e cause of death?	
ord	w require been sig should t	ted	DIARETES A		<u> </u>						1 🗆 Y	es 2 🗆 No	3 🗌 Proba	ably 4 Unknown	
ecc	e law r has be je 2 sh	Completed	HYPERTEN	NOV							24a. Was a		. Were autop	psy findings available	
= =	The effert	Con									perfor 1 ☐ Yes	med? 2 No	death? 1 ☐ Yes	2 🗆 No	
Vita	Attending Physicien: The reath. •ctor: After this certificete by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	(Check only or	10)			
o	문문	- To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatier 28b. Time of			4 LINU		me 5 Residence 128d. Describe h			′)	
O	th. th. : After s funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Mont	h, Day Year)	Injury	м	8c. Injury Work 1 □ 1	:?` /es 2 □ l		200. 2000. 20 11	on injury cood			
Division of Vital Records,	Attendi r death. ector: A by the fu	fice	3 Suicide 6 Could no 4 Homicide determin	and 286. Place	of Injury - At h	iome, farm, str	eet, factory	, office					ber or Rurai	l Route Number,	
ā	tel or rs afte al Dire	Certification:	4 Tromicide	Dulldir	ng, etc. <i>(Speci</i>	(Y)					City or Tow	n, State)			
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the ba and mann	isis of examina	owledge, deatl ation and/or in	n occurred vestigation	at the tim , in my op	e, date an inion, dea	d place, a th occurr	and due to the c ed at the time, d	ause(s) and m late and place	nanner as sta , and due to	ated. the cause(s)	
	To th Withir To th comp	M	29b. Signature and title of centier				290	. License	number		2	9d. Date sign	ed (Month, L	Day, Year)	
	_		Leura	ziberen-	AL D		D	27	886		1	Ward	2 28	2006	
	6		30. Name and address of person w	ho completed caus	e of death (Iter	m 23a) (Type,	Print)		Λ				^	0	
			31. Date filed (Month, Day, Year)	N. N. S 150	225 SIA	AN GRO	VEKO	-201	Ka	KUIL	LE MAR.	CUAN	20851	0	
1	Sta Registr		MAR 2	9 2006 D	austral 5 Sign	A. A.	2001	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Month Pinkney, Jr. Lewis March 26,2006 10:15AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5309 Mellwood Park Ave. Upper Marlboro Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 18, 1955 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2□F 215-64-5058 50 Wash. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehor 1X Yes 2 No MD Prince Georges Upper Marlboro Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5309 Mellwood Park Ave. 20772 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itame 14. Race - American Indian, 11. Marital Status r than "natural", or itame the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Ie marked other then "natural", or Iter 1 X Never Married 2 ☐ Married □Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 20XNo Specify: Black If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Security Storage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Pinkney, Sr. 2 Mary L. Pinkney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) Louise Toler/Sister 5309 Mellwood Pk. Ave. Upper marlbor, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition artment of h ortant: if its injury or of XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Thomas 3/29/06 Baden, Maryland permit.
Departr
imports
eny inj 22. Name and Address of Facility Home, PA 20005 Aquasco, MD PA 20605 Aquasco Rd. Adams Funeral 23a. Part 1. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only she cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCEN THOAT Physic an /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physicien ar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificate 1 ☐ Yes → No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification; To 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital 29a. Certifier 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) ŝ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D35206 \uma ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 11701 Livington Rood, Fort WASHington hone po 31. Date filed (Month, Day, Year)

State

Registrar

egistrar's Signature

2006

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	*	4	1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Pamela 1	. Pinkney				March 2	5, 2006	2:12 P M
	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. County of Dea	
		Jil.	Prince George's F			Chever	lf Under 24 Hrs.	9 Date of Birth		e George's
	Funeral Director		217-46-9847	9x □ M 2□ X F	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,)	1°9′50 Ma	thplace (State or Foreign puntry) ryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	Cation Carlboro				10d. Inside City Limits
	Mary -1 • hc	ğ	MD Prince	Georges Up	per M	ariboro				1 X Yes 2 □ No
	ih with the 23s or 28s	Funeral Director	10e. Street and Number 7901 Croom Rd	•		10f. Zip Code 2	0772	100	g. Citizen of What Co USA	ountry?
036	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or iteme 23a or 28a-f ehow event, the Madical Estining methods to citied at	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
2 -0	72 ho	eted	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup	during most of worl	ting 16	6b. Kind of Business	/Industry
21215-0036	d within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	bo NOT use retired stal Sup	1)		US Posta	l Service
ਠ	should be filed nd Mental Hygii marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) George Walls				18. Mother's Nam Ethel	Griffi Griffi		
Maryland	nd 2 shoul lith and Me 27 is mark r traumati	Ť	19a. Informant's Name/Relationship (Jessica Pinkne	Type, Print) y/Daughter	19b. Maili 790	ng Address (Street Croom	and Number of Ru. Rd. Upp	er Marl	City or Town, State	^{Zip} 20772
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic a <u>pnce</u> .		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emetery, cre	osition (Name of matory or other place ection	^{ce)} 4/1		oc. Location - City or Clinton,	
Balt	permit. Departimporti		21. Signature of Mineral Service Licer	191	2	2. Name and Addre Adams Fu	ss of Facility Ineral H		20605 Ac	uasco Rd.
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	n. Do not en	ter the mode of dyir	ng, such as cardiac			Approximate Interval Between
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P.O. Box 6	death certifi e attending ed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ② No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3[☐Ectopic pregnancy ☐ Other (specify) _	1		23d. Date of de Month	livery Day Year
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Division of Vital Records,	The law require ate has been si page 2 should i	Completed				<u> </u>		24a. Was an autopsy perform	ed? death?	utopsy findings available completion of cause of
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× ×	Physician: r this certifica ral director, I	ဥ	1 XYes 2 □ No			nt 3□ DOA Oth	4 Linursing n		ce 6 □Other (Spe	ocify)
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isio	Attending or death. ector: After by the fune	licat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not b	TTULYCIN (S) CHLAD	2'-00		165 212110	28f. Location (Stre	eet and Number or R	ural Route Number.
<u>S</u>	after after Dire	Certification:	4 Homicide determined	building, etc. (Specif)	(hua			City or Town,	State)	1, Lanhamino
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C		ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea	th occurred at the til		and due to the cat	use(s) and manner a	s stated.
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and marmor stated.		29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)
	- 5 - 0		Joishar Je	eel mo		0	.C.M.E.	I	March 26,	2006
0	y 15	110	30. Name and address of , erson who				_			
1	06		Tasha Z Green be				Street, I	Baltimore	, Maryland	1 21201
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 9	32. Figistrar's Signa	ture	beele				

			State of Maryland / Dep			giene 006 11675			
				ertificate of Death CCI		Reg. No.			
п	Physici	an	1. Decedent's Name (First, Middle, Last) Marie S. Postles	}	Date of Dea Month	eath 3. Time of Death			
100	/Medic	cal	Marie A. Postles		March 2				
1	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of Dealh			
	C		913 Goldsboro Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Barclay if Under 1 Year If Under 24 Hr	s. 8. Date of Birth	Queen Anne			
	Funeral Director		222-20-8314 1□ M 2♥ F 85 Yrs.	Months Days Hours Mir		(, Year) Country)			
	ס		Usual Residence of Decedent		0000	1920 Maryland			
	unyfar show	_	10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits			
	8a-1.	cto	Maryland Queen Anne Temple	ville		1 ☐ Yes 2 No			
	Vith th	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?			
	s 23g	erai	107 Bear Pond Road	21670		U.S.A.			
	ter d	by Funeral	11. Marital Slatus 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2∑No	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- nto Rican, etc.)	14. Race - American Indian, Black, White, etc.			
936	urs af	by	3 ØWidowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White			
Ò	within 72 hours after death with the Maryland ene. Itan "natural", or Items 23e or 28e-f show he Madical Examiner must be notified at	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/Industry			
21215-0036	Man "	pje	College (1-40f 5+)	e kind of work done during most of we DO NOT use retired)	orking				
7	ed wi	Completed	07 Sh:	ipping Clerk		manufacturing			
<u>n</u>	d oth	Be	17. Father's Name (First, Middle, Last)		ime (First, Middle,	Maiden Sumame)			
aryland	1 Men narke	T	unknown	unknow					
a Z	12 st h and 7 te n traun		The state of the s	ing Address (Street and Number or F					
ტ _	Healt Healt Her ther		George Roger Satterfield/ son PO I	Box 187 Kenton,					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportment if them 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once.		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		20c. Location - City or Town, State			
	artme ortani injury			S Chape1 Cem 03/	30/06	Frederica, Delaware			
Ba	Depa Impo Impo any i		Id , old , FI	eegle and Helfen	bein Fune	ral Home, P.A.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	Box 160 Greensbe	oro, Mary	land 21639 est. Approximate			
99	Physician		Immediate Cause (Final	0- 11		Interval Between Onset and Death			
Ř	/Medical		disease or condition resulting in death) Due to (or as a consequence of):	1) KEG-	186-17	41100			
Е	Examiner		Paleu mani 6	·C					
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying)				
	acuted nd trans	Examine	Cause (Disease or injury that initiated events c. /u/mu/u/	y Hyperten	5,00				
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8760,	icate be executed physicien and s the burial-transit	dlcal	d						
×	eath certifi ettending I for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy						
X R R	death certifi e ettending id for use as	cian	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		23d. Dale of delivery Month Day Year			
oj.	by the de tached	ysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 [9 ☐ Unknown						
J	law requires that the es been signed by th 2 should be detache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of							
Hecords,	quire n sig uld bu				1 🗆 Ye	es 2 10 16 3 Probably 4 Unknown			
ပ္တ	sw requir s been si 2 should l	Completed			24a. Was a	n 24b. Were autopsy findings available			
Ì	sician: The lav certificete hes irector, page 2	E			autops	n 24b. Were autopsy findings available prior to completion of cause of death?			
	tor, p	BeC	25. Was case referred medical	26. Place of De	1 ☐ Yes 2 ath Check only on	2.12/No 1 ☐ Yes 2 ☐ No			
> i	× ∞ 0	2	examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other	Home 5 ☐ Reside	1 Ans 11			
	ding Pth h. After th funerel		27. Mannar of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of (Month, Day Year)	f 28c. Injury at Work?	28d. Describe ho	ow injury occurred 210109			
200	Attending r death. ector: After by the fune	catl	2 Accident investigation	M 1 ☐ Yes 2 ☐ No					
UNISION	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (St. City or Town	(Street and Number or Rural Route Number, own, State)			
			29a. Certifier 1 Certifying Physician: To the best of my knowledge deal						
	Fun Fun	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the basis of examination and/or in and manner flated.	h occurred at the time, date and plactivestigation, in my opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner as stated. ate and place, and due to the cause(s)			
	within 2 To the complet	Me	29b. Signature and the of certifier	29c. License number	29	9d. Date signed (Month, Day, Year)			
) '	- 31-0		> \b non- b Anval	400/21	122	2/20/16			
			30. Name and addres. of erson who completed cause of death (Item 23a) (Type.	Print)	00	5101100			
			- 3 //	ll Rd #200; Chest	ertown M	m 21620			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	L. No. "200; Ollest	CI COWII	2.020			
	Registra	ar .	MAR 9 9 2000 N	1					

PARLUCK, JOHN

		1	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			iene	6 11676
i ş	Physici /Medic		Decedent's Name (First, Middle, Last) JOHN PARLUCK					2. Date of Deat Month March	Day	Year 1915 M
_	Examin		4a. Facility Name (If not institution, give st. + HE MEMOR 5. Social Security Number 6. Sex	IAL H	DSPITAL (In yrs. last birthday)	4b. City, Town, or EAS If Under 1 Year Months Days		h 8. Date of Birth		of Death 7 L BOT 9. Birthplace (State or Foreign Country)
	Director		087-30-2442	M 2□F	90 Yrs.	Months Days	Hours Min.	DEC. 22	1915	NEW YORK
ore, Maryland 2	nyland phow	Director	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	the Ma		MD TALBO	<u>r</u>	EAS'	10f. Zip Code		1	0g. Citizen of V	1X Yes 2 No
	3a or		700 PORT ST.				21601		og. Omzeri or v	USA
	be filed within 72 hours after death with the Maryland ital Hygiene. Indicate them "natural", or Items 23a or 28e-f show event, the Medical Examinar must be notified at	To Be Completed by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 □ Yes 2 ▼ N If Yes, Give Year or Dates:	0	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Blac	e - American Indian, ck, White, etc.
	within 72 ho ine. then "natur in Wedical I		15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5-	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of wo 1)	rking	DAIRY	isiness/Industry
	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)	0	DA	LIRY FARMI		me (First, Middle, I		
	should be filed of Mental Hygin marked other matic event, I		WILLIAM PARLUCK				PAUL	INE SEEME	CHUCK	
	2 m = 2		19a. Informant's Name/Relationship (Type			ng Address (Street a			74 Table	
	1 and Health em 27 other tr		MITCHELL J. CORNW. 20a. Method of Disposition	ELL/NEPHE	20b. Place of Dispo	O OAKLAND: osition (Name of		-		D 216U1 City or Town, State
	Peges 1 ment of H ant: If Iter ury or oth		1 ☐ Burial 2 【A Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		matory or other plac KE CREMAT	· 1	3/29/2000	5 STEVE	NSVILLE, MD
Balt	permit. Pege Department Important: If any Injury or once.		21. Signature of Funeral Service Licenses		2	PELLOWS, 1200 S. HA	ss of Facility HELFENBE RRISON S	IN & NEWI	NAM FUN	ERAL HOME PA
Division of Vital Records, P.O. Box 68760, Hospitel or Attending Physician: The law requires thet the death certificate be executed to the process after death.	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
	ficate be executed y physicien and stree burial-transit	ation; To Be Completed by Physician/Medical Examiner								
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (s <i>pecify)</i>	'	The state of the s	23d. Dat Mor	e of delivery nth Day Year
	w requires thet the de been signed by the a should be detached f		Part II. Other significant conditions continuously to death but not resulting in the unionlying cause given in Part II.							
	: The law requirete has been page 2 should							24a. Was a autops perform	ned?	Nere autopsy findings available prior to completion of cause of death?
	sician: Th certificete irector, pag		25. Was case referred to medical examiner? 1 Tes 2 No Ho	spital:		other actions Other	00	ath Check only on		
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page		27. Manner of Death 1. Stratural 5 Pending 2 Accident investigation	28a. Date of Injury			ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
	itel or Attenurs after deat rel Director: iled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	. (Specify)				n, State)	eet and Number or Rural Route Number, State)	
	the Hospite in 24 hours the Funerel pletely filled	edicai	29a. Certifier 12 Certifying Physic (Check only one) 2 Medical Examine	er: On the basis of and manner state	examination and/or in	h conumed at the tim exestigation, in my or	ne, date and place pinion, death occi	s, and due to the durred at the time, d	ate and place, a	and due to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	10	221	29c. License	e number		-	(Month, Day, Year)
	6-		30. Name and address of person who com	•			110			1 29 2006
	9 -		DENNIS M. DESHIEL			HINGTON S	T EASTON	, MD 216	01	
4	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1 2005	Hegistra	r's Signature	120				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month WILLIAM NORMAN PORTER, SR. Marc 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number If Under 24 Hrs. morio 8. Date of Birth (Month, Day, Year) FEB 15, 1939 1 Year 9. Birthplace (State or Foreign 5. Social Security Numbe 6 Sax 7. Age (In yrs. last birthday) Months Davs Hours Min 1**X** M 2 ☐ F MARYLAND 217-36-0188 67 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 1 Yes X No MD CAROLINE PRESTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21655 2673 MYRTLE AVE. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Amed Forces? Black, White, etc. Med Forces? XYes 2 ∏ No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) HANDICAP Elementary/Secondary (0-12) College (1-4or 5+) 12 DRIVER TRANSPORTATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CARROLL HOLLIDAY PORTER MARY CATHERINE JARVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23514 WELTY CHURCH RD., PO BOX 51, SMITHSBURG, MD GRETCHEN H. VAUGHN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 4/6/2006 HURLOCK, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON -OHN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pontine Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of) incorprolled OYONON IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a Was an autopsy performed 2 No 1 Yes 26. Place of Death (Check only one) Hospital: 1 Ampatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending

Examine The law requires that the death certificate be executed burial-transit Box 68760, attending physiclan Physician/Medical use as the ō ed by the a Records, Be Completed by cate has been signated by certificate Division of Vital Hospital or Attending Physician: funeral director. Certification: To After death. sctor: the

P.O.

Physician

/Medical

Examiner

Funeral

Director

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f Health

Department of H Important: If Ite any injury or ot once.

Physician

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Examiner

90 Mental marked

Maryland

Baltimore,

Director

Completed by Funeral

Be

other traumatic event, the Medical Examiner must be notilised at

25. Was case referred to medical examiner' 1 ☐ Yes 2 ☑ No 27. Manner of Death

29a. Certifier

(Check only one)

1 TYes 2 No

2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier MY 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haider m

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

filled in by

completely

Medical

within 24 hours after of the Funeral Direct

31. Date filed (Month, Day, Y Year) 1



Division of Vital Records. P.

Director: d in by the f

Hospital or Attending Physician:

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Registrar

To the l

Laron Locke MD. 31. Date filed (Month, Day, Year) State

∕Sig≀

3

Suicide

Homicide

Assistant Medical Examiner

address of person who completed cause of death (Item 23a)

Could not be

determined

APR 1 3 2006



28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

(Specify) Major Road / Highway

28f. Location (Street and Number or Rural Route Number, City

29d Date signed (Month, Day, Year)

or Town, State) Rt. 50 @ Ridge Road, Burlington, WV

April 4, 2006

Austin Groleau Rottier Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-02183 State of Maryland / Department of Health and Mental Hygien crn 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** РМ 2006 Austin Groleau Rottier March 8:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 337 East 31st Street N/A Baltimore 8. Date of Birth Month Day, Year) Nov 9, 1984 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 11 м 2□ F Months Days Hours Yrs. Washington DC 219 17 1505 21 Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Ellicott City Howard Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9729 Cypress Mede Drive 21042 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 225 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Student Education or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental John Ross Rottier Georgina Groleau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Ross Rottier/Father 9729 Cypress Mede Drive Ellicott City, MD 21042 t of Health : Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Peges 1 Department of H Important: If Its any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-31-2006 Catonsville, MD Metro Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc MICO 535 4112 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intraoval Shotaun Wound /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence off. Examine the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ₽ Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown À Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 🐧 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? hes After this certificete 1/2 Yes 2 🗌 No or Attending Physician: 25. Was case referred to medical examiner?
1 🗓 Yes 2 🗌 No director, 26. Place of Death Check only one Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at SCENE ဥ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Franking pm 1 Natural 5 Pending 3/29/06 Subject shotself 1 ☐ Yes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 3 Suicide 4 Homicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 337 E315+ 5+ Balthiwer ERD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

A Part Trull of filled in by Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical completely (Check only one) ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME March 30, 2006

7 Jm State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ANMO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H 3 1 2006 Marian signature

111 Penn Street, Baltimore, Maryland 21201

Months

Yrs.

Days

Hours

Min

Funeral Director r 28a-f show traumatic event, it a Medical Examiner must be Baltimore, Maryland 21215-0036 f Health

Physician /Medical Examiner 1 - For State Registrar

215-26-1972

t**∕**2 M 2 □ F

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Physician

/Medical

Examiner

The law requires that the death certificate be executed physician and s the burial-transit Records, P.O. Box 68760, use as signed by the eld be detached for of Vital efter death.

Director: After this certific
d in by the funeral director, Division within 24 hours efter des To the Funarel Directo completely filled in by th

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Washington Boonsboro Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 6127 Old National Pike 21713 USA Completed by Funeral 12. Was DecedenI Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedenl's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) painter construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore S. Routzahn Esta Mae Younkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Ford Ave., Boonsboro, MD 21713 Sherry Finzel (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Reformed cemetery 4/3/06 Middletown, MD 4 □ Denation 5 □ Other (Specify) 21. Signature of Humera Service Licens Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 23al Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 15 chemic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neumma 1 Yes 2 No 3 Probably 4 Onknown Stocke 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Hospital: 1 ☐ Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Sertifying Physician: To the best of my knowled je, death occurred at the time, date and judge, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 301-432-8470

ZAFAR MALIK, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 3 1 2006

			1 - For State Registrar	State of M	/larylar	-			ealth a Death	and Me		iene	16	1681
	Physici	an	1. Decedent's Name (First, Middle, Las	•							2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic		Robert Clint								March		2006	11:15 A ^M
	Examir	ner	4a. Facility Name (If not institution, give 7 Tulip Drive	street and number	r)		4b. City		Location o		• 0		y of Death Ltgome	2 r 17
	Funeral		5. Social Security Number 6. Se	9x 7. A	ige (In yrs.	last birthday)		er 1 Year	If Under		_		9. Birth	olace (State or Foreign
	Funeral Director			M 2□F	81	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, July 28	3,1924	Cou	yland
	pu.		Usual Residence of Decedent 10a. State 10b. County	-	10c Cit	ty, Town or Lo	antion						1.	10d. Inside City Limits
	Aarylan f show ed at	៦	MD Montgo	m 0 1 737	100.00			rsbu	ra					1 TYPes 2 □ No
	28a-	Director	10e. Street and Number	mery				ip Code	L B		1	0g. Citizen of	What Cou	ntry?
	h with	i D	7 Tulip Drive					2	20877			United	Stat	tes
	ams ams	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U	J.S. 13.	Was Dec	edent of Hi	ispanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		ce - Americk, White,	can Indian,
36	within 72 hours after death with the Maryland ene. Itan "natural", or Itams 23a or 28a-f show Ita Mazical Examiner cust be millied at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give Year or Dates		II	1 🗆 Yes	2 ∑ No	Specify:			Speci		White
21215-0036	e hour	ed t	15. Decedent's Ed	ucation		16a. Dece	dent's Us	ual Occupa	ation			16b. Kind of E	Business/In	dustry
215	hin 72 9.	Completed	(Specify only highest gra-	de completed) College (1-4o	r 5+)	(Give	kind of w DO NOT	ork done d use retired	luring most)	t of workin	g	Associ	atior	ı of
2	ed wil	Con	12				Rai1	road	Work					ailroads
Maryland	be fill Had Had oth	Be	17. Father's Name (First, Middle, Last) George Reber								(First, Middle, I neberge		me)	
ž	hould d Mer marka matic	2	19a. Informant's Name/Relationship (7	vne Printl		19h Mailir	na Addres	s (Street a			Route Number		State Zir	Code)
Ma	ith an		Alan C. Reber /								ckville	-		, ,
re,	of Hear itam otha		20a. Method of Disposition		20b. F	Place of Dispo	sition (N	ame of		Da	ate	20c. Location		own, State
im	ment ant: If		1 X Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify		e Pa	rklawn Par				arch 2006		Rockv	-	
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show any printy or other traumatic event, its Madical Examiner must be neitlifted at once the property of the madical Examiner must be neitlifted at		21. Signature of Funeral Service Licen			22 D	Name a	nd Addres Park	of Facility Drive	y DeV ∍, Ga	ol Fune ithersb	ral Ho urg, M	me, 1 D 208	0 East 377
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caus one cause on each	ed the deat line.	th. Do not ent	er the mo	de of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
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	/Medical Examiner		1	Due to (or a										
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90	e execian ar	Ex	resulting in death) Last	Due to (or a	is a conseq	quence of):								
8760,	physic the b	dicai	•	d										
9 x	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregna	ancy						23d Da	ate of delive	arv
Box	death e atter d for u	Physician/M	in the past 12 months?	1☐Live birth 4☐Pregnant	at time of c		Ectopic Other (s	oregnancy specify)			<u>.</u>		onth	Day Year
P.0	that the ded by the detached	hys	9 🗆 Unknown	9□ Unknown		<u> </u>				·				
	uires thal signed b d be det	by	Part II. Other significant conditions co	ontributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.		1			he cause of death?
Vital Records,	w requir been si should	Completed									-			pably 4 □Unknown
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a		e Co	25. Was case referred to medical				<u></u>		OC Place	of Dooth	1 ☐ Yes 2	2 X No	1 🗆 Yes	2□ No
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sioi	ttandir death. ctor: Af / the fu	catic	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 1					
Division of	or Att	Certification:	4 Homicide determined	28e. Place of I	njury - At h etc. <i>(Specil</i>	ome, farm, str fy)	eet, facto	ry, office		21	8f. Location (St City or Town		ber or Rura	al Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 X Certifying Ph	ysician: To the bes	st of my kno	owledge, deat) occurre	d at the tim	ne, date an	d place. at	nd due to the ca	ause(s) and m	anner as s	tated.
	ia Hos n 24 h na Fur iletely	Medicai	(Check only 2 Medical Examone)	niner: On the basis and manner:	of examina	ation and/or in	vestigatio	n, in my op	oinion, dea	th occurre	d at the time, da	ate and place,	and due to	o the cause(s)
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•			16	/c	er	1		17.1	ان ر	.00		March :	21 , Z	
l	0+1		30. Name and address of person who carlos E. Picone.					70.55	#020) (1	01		2001	C
	Sta	10							11930	, Ch	evy Cha	se, MD	2081)
	Sta Registi		31. Date filed (Month, Day Year) 9	2006	we .	ature A	parks	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Patricia Jean Reeves 2006 April 7:52 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Egle Nursing & Rehab Center Lonaconing Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min. 1 ☐ M 2 🕱 F Months Hours 20,1924 81 Director 216-22-7117 Three Forks, WV Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Rawlings Allegany | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19812 Biddle Drive, S.W. USA Funeral 21557 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 3 ₩ Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Certified Nursing Assistant 12 should be filed with and Mental Hygien 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilson C. Wilt Effie May White 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar d item 27 if Wanda Swick/ Daughter 471 Newton Street other t Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If itel
any injury or oth April 6 2006 1 Burial 2 □ Cremation 3 □ Removal from State Garrett Co. Mem. Gardens * 4 □ Donation 5 □ Other (Specify) Oakland, MD 22. Name and Address of Facility Smith Funeral Home 21. Signature of Funeral Service Licenses Ducen 85 S. Main Street Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Menul Failure y ea/s disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician 99 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐Unknown pleted been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Com The 2 🗆 No 1 Yes Division of Vital To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No ည this funeral c 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 121488 5-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas J. Devlin, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 1

32. Radistrar's Signature

2006

Appelle ...

20 Douglas, Avenue Lonaconing, MD 21539

Specify only improved years of monitoring property of the service of the property of the pro				For State Registrar	State of	Maryland /	-	artment rtificate			and M		giene	J6	11683	3
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Sequentially list conditions, authority to grade a sequence of light in the late of late of late o				disease or condition	a. Due to (o	ras a consequence	LLYC.		an	(Ve	ari	c Ca	nce	1		
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Signalury and title of certifier 29b. Signalury and title of certifier 30b. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Kaman B Kanews 34 Malcul M duve, Wort Minuth MD 21157 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		utter th				Injury 28b. Day Year)			3c. Injury Work	at ?	2					
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Danielman		Sta	te	31. Date filed (Month, Day, Year)			, ,	10-(1	Cr. 1 - 7			- / /	11.41	., 5	2/13)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 17 18 per fh 2854 4-20-06 vt.
State of Maryland / Department of Health and Mental Hygiene

1- State Registrar AMEND#19b, per.HH, 3/29/2006, DPS, MccoCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 24 2606 **Physician** FLORENCE SKOGLAND 708 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL DLNEY MONTGOMER 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

9.2 Yrs. | Months | Days | Hours | Min. 5. Social Security Number 6 Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 577-01-7585 1 ☐ M 2 反 F 92 Yrs Director APRIL 18, 1913 MASSACHUSETTS Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ie filed within 72 hours after death with the Marylan at Hygiene.
I thygiene i natural', or Items 23e or 28e-f show yent, the Mackles Explaint rount be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo MARYLAND MONTGOMERY SANDY SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17350 QUAKER LANE #121 20860 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOK KEEPER RETAIL permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent: If Item 27 is marked other eny injury or other treumatic event, 17. Father's Name (First, Middle, Last) Grayson 18. Mother's Name (First, Middle, Maiden Sumame) Be Eva D. Griffiths ERNEST GREYSON EVA UNKNOWI 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE HINDS - DAUGHTER 4913 BRAMPTON PARKWAY; ELLICOTT CITY MD 20904 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State d 1 KBurial 2 Cremation 3 Removal from State FORT LINCOLN CEMETERY 3/28/2006 4 □ Donation 5 □ Other (Specify) BRENTWOOD, MD 21. Signature of Funeral Service Licensee HINES-RINALDI FUNERAL HOME 22. Name and Address of Facility pode Myslin T. Klobert 11800 NEW HAMPSHIRE AVE; SILVER SPRING MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate nterval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY EMBOLLSM WEEK /Medical Due to (or as a consequence of): Examiner WEEK PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physicien and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ATRIAL FIBRILLATION 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 1 Yes 2 No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 💢 No this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation М 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after within 24 hours a To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D62656 MARCH 24, 2006 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SONIAHOLMES, M.D. 18101 PRINCE PHILIP DRIVE, DLNEY, MARYLAND 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature ADBALL) Registrar MAR 2 9 2006

			1 - For State Registrar	State of Maryland / D	epartment of He Certificate of D			ne 2006	11685
			Decedent's Name (First, Middle, Last)	1-1-1-1			2. Date of Death		3. Time of Death
Н	Physici		JAMIES		STEDI	PINS	MALCH ?	Day Year	4:47 AM
r	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or L	ocation of Death	7711-6	4c. County of Deat	h
			The Johns HOP,	Kips Hospital	BAlti	MORE		Baltim	ore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birtl	nplace (State or Foreign untry)
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	and		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
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	28a	Director	10e. Street and Number	CLY AS	10f. Zip Code		10g	. Citizen of What Co	untry?
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	deatl	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hisp If Yes, specify Cuban,		ecify Yes or No-	14. Race - Ame	
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ary	shou and N ama umal	-	19a. Informant's Name/Relationship (Ty)	рө, <i>Print)</i> 19b.	Mailing Address (Street an				ip Code)
Baltimore, Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mental thygiene. Important: if item 27 is marked other than "natural", or flems 23a or 28a-f show any injury or other traumatic avent, the Madical Examiner must be notified at ADDE.		Mamie Stephens-	Wife 18	320 New Hat Disposition (Name of	moshire	Ave As	hton, MI	20861
ore	2 2 2 2 5 C		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ R	comoton	Disposition (Name of , crematory or other place)	- C	ate 20	c. Location - City or	Town, State
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П			23a. Part1. Enter the disease or compli- shock, or heart failure List only on	cations that caused the death. Do not be cause on each line.	ot enter the mode of dying,	such as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
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	/Medical Examiner			Due to (or as a consequence of	f):				
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Box	th ce tendir	an/	230. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy			23d. Date of deli	
<u>.</u>	e dea the et ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)			Month	Day Year
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<u></u>	ath. T: Afte	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Inj		s 2 No			
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•	_, ī		30. Name and address of person who co				1/1/	TRUM 21	2006
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		1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H tificate of L			iene	6 1	1686
	250	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month		Yeer	3. Time of Death
Physic /Med		Iren E	•	Soltesz			March 2	4,2006	7001	6:45 A M
Exami		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of	of Death	
		11227 Woodson	Avenue		Kensin			Montg		
Funeral		Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 2	Year)	9. Birthplec	e (Stete or Foreign
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and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d.	. Inside City Limits
Aaryl f •ho	ō	MD Montgom	erv	Kensing	ton					1 ☐ Yes 2 🎇 No
the t	rect	10e. Street and Number	Ci y	, cirsing	10f. Zip Code		1	0g. Citizen of W	hat Country	?
3e or	Ö	11227 Woodson	Avenue		20895			Hung	arv	
death me 2:	Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S. 13.)	Was Decedent of H	ispanic Origin? (Spo	ecify Yes or No-	14. Race	- American	
or its		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣 No		t Yes, specify Cuba 1 □ Yes 2 🖾 No	n, Mexican, Puerto	Hican, etc.)		, White, etc	
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led v tygie her t		17. Father's Name (First, Middle, Last)		ноп	nemaker	18. Mother's Name	a (First Middle A			
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d Me	ို	19a. Informant's Name/Relationship (T)		19b Mailir	ng Address (Street a	and Number or Rura			State Zip Co	ode)
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Datititioie; Inial yialing £ 1.2.13-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, its Modical Examinar must be rotified at any once.		20a. Method of Disposition		20b. Place of Dispo	sition (Name of			20c. Location - C		
ages ont of t: H H	1	1 Burial 2 Cremation 3 ☐F 1 Donation 5 ☐ Other (Specify)		-	natory`or other plac Heaven (em. 03/2	7/2006	SilverS	prina	MD
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201	<u> </u>	23a. Part 1. Enter the disease, or comp	lications that caused	the death. Do not ent					A	pproximate Iterval Between
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attendir for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	Fetal death 3	Ectopic pregnancy			23d. Date Mon	of delivery th Da	ay Year
e and bed	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death 5 L	Other (specify)					
T tad by belge by	Ph	Part II. Other significant conditions co	ontobuting to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did tot	pacco use contri	bute to the	cause of death?
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e law has b	mpi						autops perform	y pr ned? de	rior to compleath?	letion of cause of
VICAL DEC SICIAN: The law certificate has b irector, page 2 s							1 ☐ Yes 2	2√No 1	☐Yes 2[□No
VILGI sician:] certifical irector, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ☐ ER/Outpatier	nt 3□ DOA Oth	er: A D Nursing He	me 5 % Reside		s (Considu)	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	4 Homicide	building, etc	. (Specify)			City or Town	i, State)		
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j		30. Name and address of person who o							TATION OF THE PARTY OF THE PART	
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100	tate	31. Date filed (Month, Pay, Year)	32. Registra	r's Signature	10 a 10 2					
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ith, Larry		Sta 1- For State	ate of Mar		partment of		ind Ment	al Hygiene		
Dhyaisia		Registrar 1. Decedent's Name (First, Middle	a Last)	Ce	ertificate of	Death		2. Date of I	Reg. No.	106, 158
Physicia dical Examin	-	Larry Smit						Month April 3,	Day Yes	11:43
)		4a Facility Name (if not institution Prince Georges Hospi		d number)	4	o. City, Town, Cheverly	or Location of		4c. County	of Death George's
Funeral	_		6. Sex		. last birthday)	If Under 1 Y		1	8 irth (MM/DD/YYY	9. Birthplace (State or Foreign Country)
Director		579–72–3913	M 2	F	52 Yrs.	Months D	ays Hours	Min. Feb	. 23,1954	Washington, DO
aux		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Locatio	n				10d. Inside City Limits
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ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	·			10f. Zip Code	9		10g. Citizen of W	hat Country?
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11215-0036 Id be filed within 72 hours af fental Hygiene arked other than "natural event, the Medical Examin	Completed by	 Decedent's Education (Specific Elementary/Secondary (0-12) 		grade completed) ge (1-4 or 5+)	during			ind of work done		usiness/Industry Ct Of Columbia
336 thin 7. than than	nple	12th	00.100	30 (1 10, 0.)	Firefi		NOT use ret	irea)		epartment
5-0036 led within 7 Hygiene other than	Co	17. Father's Name (First, Middle,	Last)		111611	girei	18.Mother's	s Name (First, Midd	le, Maiden Surname	
AD 21215-0036 2 should be filed within h and Mental Hygiene 27 is marked other than matte event, the Medic	Be	William Smith					Cam	illa Unk	nown	
D 21 thould nd Me is ma	ď	19a Informant's Name/Relationsh								vn, State, Zip Code)
P H H E R		Doris J. Smith	1 W	life	5473 D. Place of Disposit	Addis	on Road	d Capitol	Heights,	MD 20743 - City or Town, State
ore of H of H If i		1 X 8urial 2 Cremation	3 Remov	al from State	crematory or oth	er place)			200. Eddallon	Oily of Town, State
		4 Donation 5 Other Sp		Н	armony M				Lando	over, MD
Balti permit. Departm Imports		21. Signature of Funeral Service			Au	stin R	oyster	Funeral	Home_	
Physician	,	23a Part I. Enter the disease, or	complications th	at caused the dea	th. Do not enter th	$21\ \ 14t]$ e mode of dyi	h Stree	et NW Was ardiac or respiratory	hington, arrest, shock, of he	DC 20011 Approximate Interval
/Medical		failure. Lest only one cause Immediate Cause (Final disease	on each line.	iomyopathy						Between Onset and Death
Examiner		or condition resulting in death)		as a consequence	of):					
(N	.	Sequentially list conditions,	b.							
	Examine	If any, leading to immediate cause. Enter Underlying Cause	C.	as a consequence	or):					
Si. d	xan	(Disease or injury that initiated events resulting in death) Last		as a consequence	of);					
xecuted n and l - transit	ä	V	d.	i+~~#?	20 DTT 27	norME of	DEE E/10	/oc mr		
2 2 c	edic	X UNPENDED	AMEND		3a,PII,27,	perm, go	/10 /دودد	00 11		
Box 68760, death certificate be the attending physic of for use as the bured for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	•	res, outcome of pre ive birth		al death	3 Ectopic	pregnancy	23d. Date of Month	f delivery Day Year
ox 6 ath cer attendi	icis		nown -	regnant at time of	death 5 Oth	er (Specify)				
. BC the deal	Phys	Part II. Other significant conditi	90	nknown	t reculting in the u	adortying caus	o given in Per	#1 220 D	id tobosco una cont	ribute to the cause of death?
P.O.	β	Mitral and tric		-			se giveri iii Fai	1	Yes 2 No 3	
ords, w requires to been sig	Completed by		uspiu rea	guigitation	r, pyeronep	штиъ,		24a V		Were autopsy findings available
taw rathas b	nple.	renal failure							utopsy	prior to completion of cause of death?
Re The ficate page	S							.1 🗸 Y		Yes 2 No
Vital Rechystrian: The lithis certificate	Be	25. Was case referred to medical examiner?	Hospital: 1	Innationt 2	✓ ER/Outpatient			Check only one)	Residence 6	Other:
n of V ding Phy.	<u>1</u>	1 Yes 2 No 27. Manner of Death	28a. D	Date of Injury	28b. Time of In		njury at Work?		ibe how injury occur	
on on carriers ath.	tion	1 X Natural 5 Pend	ing	Month, Day, Year)		1	Yes 2			
Division of Vital Records, rat or attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:		tigation 28e.	Place of Injury - At	home, farm, stree	t, factory, offic	e building, etc	28f. Location	on (Street and Numb	per or Rural Route Number, City
Div	erti		mined (Spe	cify)				or Tow	n, State)	
Division of Vital Records, P.O. Box 68760, "To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.									cause(s) and manne	
To the within To the comple	Medical	- (3)	and man	asis of examination her stated.	and/or investigati			curred at the time, o	late and place, and	
	Σ	29b. Signature and title of certifie	,				ense number			ned (Month, Day, Year)
		hig h	i, hui			0.	C.M.E.		April 4, 20	06
-		30. Name and address of person	who completed	cause of death (Ite	em 23a)					

State 31. Date filed (Month Rey Registrar

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

			1 - For State Registrar	State of I	Marylan		artment o			nental Hyg	giene Neg. No. 0	6	11688
	Physici	an	1. Decedent's Name (First, Mid	ldle, Last)						2. Date of Dea Month		Year	3. Time of Death
	/Medic		Barbara		tuart					March	26, 200		2:20 A M
	Examin	er	4a. Facility Name (If not institut	, in	*		4b. City, Tow		on of Death		1		3 - 3
			Anne Arundel 5. Social Security Number	-	ter Age (In yrs.	last hirthday	Annar		der 24 Hrs.	8. Date of Birtl		g. No. Day Year 26, 2006 4c. County of Death Anne Arundel 9. Birthplace (State or For County) 31 Indiana 10d. Inside City Lir 1	
į,	Funeral Director		314-36-1919 Usual Residence of Decedent	1□M 2XF	74	Yrs.		ays Hou		11-24-1	, Year)	Ind	iana_
	72 hours after death with the Maryland naturel; or Items 23a or 28e-f show Jical Examination ust be motified at	Director	10a. State 10b. Cour Maryland Anne	e Arundel	10c. Cit	y, Town or Le	napolis						0d. Inside City Limits 1 ☐ Yes 2 No
	ith th	Dire	10e. Street and Number				10f. Zip Co				-	Vhat Cour	ntry?
	s 23s		2709 Yeomans			C 12		401	Origin 2 (Co	andu Van ar Na		a - Amoria	ean Indian
	72 hours after death with the Marylan "naturel", or litems 23a or 28e-f show Alfeal Examinations to institute at	by Funerai	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divorc	If Yes, Give	es? K j∖No		was Decedent If Yes, specify (1 ☐ Yes 217			ecify Yes or No- Rican, etc.)	W 1,	k, White,	etc.
21213-0030	⊆ ⊒	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	ent's Education hest grade completed)	or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re	one duning r	nost of worl	ing	16b. Kind of B	ısiness/în	dustry
7	filed withir Hygiene. Ither than	Con		2 years			Homen						
Mai yiaila	0 = 0 5	Be (17. Father's Name (First, Middle					18. M		e (First, Middle,			
2		은		O. Vandervo	rt								
2	2 sho		19a. Informant's Name/Relatio		<u>_</u>	1							
ı,	s 1 and 2 should if Health and Mer item 27 le marke other treumatic		Karen L. Yand	ey/ Daugnte			osition (Name o	· · · · · ·	-	Date			
Dalilliore,	ages nt of l :: If it		1 XBurial 2 ☐ Crematio		ate C	emetery, cre	matory or other	place)					
	nit. Pa artmen ortent: injury injury		* 4 □Donation 5 □ Other 21. Signatur ■ Fuperal Service		GL		n Meml.		1	0-06			
2	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		Mulato	Uul_									
	Physician /Medical Examiner	بار	23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or	as a conseq	INFE	RIOR					TION	Interval Between
,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	as a conseq								
.0.	at the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 Yes 2 No 9 Unknown		n 2 ∏ Feta it at time of d	Ideath 3	⊒Ectopic pregn ⊒ Other (specif						
ביים,	quires that en signed t uld be det	by	Part II. Other significant cond	itions contributing to deal			Inderlying cause	-	art I.	23e. Did to			
records,	The law requate has been page 2 should	Completed			<u>-</u>					24a. Was autop perior 1 Yes	sy med?	orior to co death?	mpletion of cause of
VII	sicien: The certificate h rector, page	Be (25. Was case referred to medi examiner?						lace of Dea	th (Check only o	ne)		
5	Phys r this ral di	유	1 ☐ Yes No 27. Manner of Death 1 Natural 5 ☐ Pen	28a. Date of		ER/Outpatie 28b. Time of Injury		Other: 4 [Injury at Work?	Nursing H				(y)
DIVISION	or Atten ter deat irector: n by the	Certification;	2 ☐ Accident inve	stigation Id not be 28e. Place of	Injury - At he , etc. <i>(Specil</i>	ome, farm, st	M reet, factory, of	1 ☐ Yes 2 fice	2 □No	28f. Location (5 City or Tox		er or Rura	al Route Number,
4	To the Hospitel of within 24 hours at To the Funeral D completely filled is	Medicai Ce	29a. Certifier Certif (Check only one)	ying Physician: To the best all Examiner: On the basi and manner	is of examina	owledge, dear ation and/or in	th occurred at the	ne time, date my opinion,	and place death occu	and due to the cred at the time,	cause(s) and madate and place,	nner as s and due to	tated. o the cause(s)
	To the within To the comple	Mec	29b. Signature and title of cert			- Cy 1	4D 29c. Li	cense numb	9 4 4 6	837	29d. Date signe	d (Month,	Day, Year)
				T KENNE!	Y,			EDIC	AL +	PARKW	ar,	ANN	APOLIS HI
	Sta Regist		31. Date filed (Month, Day, Ye	2 8 2006 32. Reg	jistrar's Signa	ature A	book						

UNK 06-02124 Brandon Scott

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_
State of Maryland / Department of Health and Mental	Hygiene	ME
Certificate of Death	for U	00

11689

3. Time of Death

11:46p. [™]

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

March 27, 2006

111 Penn Street Baltimore, Maryland 21201

Year

1 X Yes 2 No

	State of Maryland / Department of Health and Me	ental Hygiene 🖺 🧎
e istrar	Certificate of Death	Reg. No.
lent's Name (First, Middle, Last)	2	Date of Death

Physician /Medical Examiner

Funeral Director

r than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at

Directo

Funeral

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Completed

Be

Baltimore, Maryland 21215-0036 Hygiene. other t and 2 should be ti Heelth and Mental Hem 27 is marked of permit. Pages 1 and Department of Heelit Important: If Item 27 eny injury or other 1 once.

> **Physician** /Medical Examiner

Examine certificate be executed and-trar physicien a s the burial-Physician/Medical as the ettending | signed by the e þ Completed page 2 s certificete Be To the Hospitel or manner within 24 hours effer death.
To the Funerel Director: After this or 2 Certification:

o

Records,

Vital

to

Division

Day 2006 Month March 26, BRANDON JASON SCOTT la Facility Name (If not institution, give street and number) Northbound on Marlboro Pike near Donnell Drive 4b. City, Town, or Location of Death 4c. County of Death Capitol Heights
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 ☐ F SEPTEMBER 29,1977 212-31-5502 28 Yrs WASHINGTON, D.C. Usual Residence of Decedent 10b. Count 10a, State 10c. City, Town or Location MARYLAND PRINCE GEORGES CLINION 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 6710 DANFORD DRIVE UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE WAREHOUSE WORKER RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) RANDOLPH SCOTT, JR. FLEADA LOCKARD SCOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6710 DANFORD, DRIVE, CLINTON, MARYLAND RANDOLPH SCOTT, JR. / FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY MARCH 31,2006 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungal Server License 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) multiple · NIC Due to (or as a consequence of): Sequentially list conditions, I any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an 1 Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify)At Scene 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred passenger auto auto collision 5 Pending investigation 1 Natural 26/06 1 ☐ Yes 2 No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) NB on Mcc love P.Ke Copital Register 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide major road 1 Certifying Physician: To the best of my knowled of death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

State

Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 2

29c. License number

OCME

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

			1 - For Amend item#5,po	State of Marylan erFH,0859,9/29/06	id / Depa	artment of rtificate of	Health a	and Menta	l Hygien	2006	11690
	Physici	20	1. Decedent's Name (First, Middle, Las					2. Dat Mo	e of Death oth D	ay Year	3. Time of Death
	/Medic		Paul Sci					Mar		2006	1:59PM
å	Examin	ner	4a. Facility Name (If not institution, give			4b. City, Town, Dent		of Death	4	c. County of Death Carolin	
	Funeral		Caroline Home for 5 Social Security Number 6.S		last birthday)	If Under 1 Yea	r If Under:	24 Hrs. 8. Dat	e of Birth	9 Rinth	iplace (State or Foreign
	Funeral Director		214-28-3201 275-20-7602	PM 2□F 78	Yrs.	Months Days	s Hours	Min. (Mo	nin, Day, Yea t 29, 19	27 Mary	land
p	>		Usuel Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or Lo	eation					10d. Inside City Limits
faryla	a ho	5	Maryland Caroline	100. 01	Denton	Cation					1 Yes 2 No
the A	28a-1	rect	10e. Street and Number		Destart	10f. Zip Code			10g. C	citizen of What Cou	untry?
death with the Maryland	3a or	Funeral Directo	27955 Greenwood Road			21629			Unite	ed States o	f America
death	i as 5	ner	11, Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Original	gin? (Specify Ye	s or No-	14. Race - Amer Black, White	
after a	유	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No			,,,	Specify:	, 616.
d Z I Z I 3-UU30 filed within 72 hours after	le Ex	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed		16a Dece	dent's Usual Occi	unation		16h		asian
in 72	and and and and and and and and and and	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retir	e during mosi ed)	t of working	160.	Kind of Basinessyn	naustry
N WE	r tha	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Farm	mer			+	Agriculture	
	al Hyg	Bec	17. Father's Name (First, Middle, Last)					er's Name (First,		n Sumame)	
yiand buid be fill	Ment arked	2	Leslie Scott					gie Drummo			
Mar d 2 sh	Deperment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or items 23a or 28a-f ahow myt fujury or other traumatic event, the Medical Examinar mail ha nothing all ance.		19a. Informant's Name/Relationship (1 Myrtle Ann Scott	урө, Print) Wile		ng Address (Stree Greenwood			-	or Town, State, Zi 21629	ip Code)
1 and	Healt em 2 ther 1		20a. Method of Disposition			sition (Name of matory or other pl		Date		Location - City or T	own, State
Pages	t: H It y or o		1 d Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval nom State				/5/2006		ncord, Mary	
	orten Orten Injur		21. Signature of Funeral Service Licen			<i>Cemetery</i> 2. Name and Add			Cor	icora, nary	ieuru.
	lmpo any l		23a. Part 1. Enter the disease, or com	. (have		oore Funer			Lon Man	yland 2162	00
6U , be executed	hysicien and properties in principle burial-transit	licai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect to the co	ATOR (uence of): OBST 6 (uence of):	Y ARR	EST			PISTASE	Approximate Interval Between Onset and Death
Geath certific	attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ıl death 3□	Ectopic pregnan Other (specify)	су			23d. Date of define Month	very Day Year
ecords, P.O law requires thet the	been signed by the should be deteched	by Pt	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause g	jiven in Part I.	. 23	e. Did tobacco	use contribute to	the cause of death?
COFGS, w requires t	en sig	led !	SOCIAL WITHD	RAWAL, FALL	URE	TO THE	IVE,		1 Yes	2 □ No 3 □ Pro	bably 4 Unknown
	as be	Completed	BEHAVIORAL CH	HANGES, DE	MEN	TIA,		24	a. Was an autopsy	24b. Were aut	opsy findings available ompfetion of cause of
E E	page.	S	ONGOING UK	INARY TRA	CT 11	VEECTION	∞	1	performed? Yes 250	death?	2□ No
VITAI iclen:	s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			thor 3	of Death (Chec			
O 4 syf	after death. Director: After this certifice I in by the funeral director, p	. To	1 ☐ Yes 2 No 27. Manner of Death	I □ Inpatient 2 □	ER/Outpatier	it 3 DOA	4 Nu		Residence	6 ☐ Other (Spec	ıfy)
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UIVISION I or Attending	r deal	ifica	3 Suicide 6 Could not be	28e, Place of Injury - At h	ome, farm, str	eet, factory, office	9	28f. Loc	ation (Street	and Number or Rui	ral Route Number,
בַּ ב	s afte	Certification:	4 Homicide determined	building, etc. (Special	(Y)			City	or Town, Sta	re)	
ne Hoepli	within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai (29a. Certifier (Check only one) 10 Certifying Ph 2 Medical Exam	ysician: To the best of my known iner: On the basis of examination and manner stated.	owledge, death ation and/or in	h occurred at the vestigation, in my	time, date an opinion, dea	d place, and due	to the cause(e time, date a	s) and manner as nd place, and due	stated. to the cause(s)
Tot	withii To the	Me	29b. Signature and little of certifier	2010/10/	Ò		nse number			ate signed (Month	
)			- Company	mill IVI-L	<i></i>	\mathcal{D}	6306	3	AF	RIL 5,	200Ce
			30. Name and address of person who			Print) 609	DAFFIL	V LAME	DENIT	TOM, MD	21629
	Sta	ate	31. Date filled (Month, Day, Year)	32 Registrar's Signa	ature			1142	PPIVI	· + 1-1/11/11/11/11/11/11/11/11/11/11/11/11/	
	Registi		APR 0 6 200	6 Dear 1	y for	sell 1					

Amend item#5, perrH, C674, 4/24/06 IT
State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Registrar

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Virginia Tate 2:39 A.M 106/2006 Helen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 3530 Churchville Road Aberdeen If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Feb. 15, 1920 9. Birthplace (State or Foreign cial Security Number 6. Sex 7. Age (In yrs. last birthday) 2266-26-8318 **Funeral** 1 □ M 2√2 F Virginia 86 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be rightfield at 1 ☐ Yes 2√ No Director MD Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21001 U.S.A. 3530 Churchville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Specify: White "natural", or 1 Yes 2 No Specify: Completed by 3€XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0 Nursing 12 Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be rermit. Pages 1 and 2 should be Cepartment of Health and Mental. In portant: If item 27 Is marked o Mamy Sheets James Newman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jerry Tate (Son) 3530 Churchville Rd Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) A. Ferris &Co. 4/7/06 West Chester, PA eny injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Lesber Aberdeen, MD 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Meta/tehic panciestro disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duarto for as a consequence off Examiner The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the a 9 Unknown 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2**X** No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No Certification: To this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide Fo the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04/06/2006 047804 o wiei 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21001 4D 16 Aberdeen MROWIEC Abardeen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	/Medic	al	CHARLES		111	ER –	1 0 3			FIARCI			11:34 P M
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Maryland	D1 (0 m m		19a. Informant's Name/Relationship (T)	*		19b. Maili	ng Address De LCT	(Street and I	Number or Rura	l Route Numbe	er, City or	Town, State, Zi	ip Code)
	1 and 2 Health tem 27		Margaret Tyler-wif 20a. Method of Disposition	e	20h P	-			. Montg	gomery		age, MD	
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examinal	tion and/or in	vestigation,	in my opinio	n, death occurre	ed at the time,	date and	place, and due	to the cause(s)
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uth	4		30. Name and address of person who co										
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Thomas, Leslie	

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		Registrar				Cer	uncate of	Deam				. Date of Dea	Reg. No.	400	0	1100
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Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying Pl	hysician: miner: ○	To the be	est of my	knowled	dge, death occur and/or investigat	red at the t	me, dat	e and pla	ce, and o	due to the ca	use(s) and e and plac	manner as be, and due	started. to the ca	ause(s)
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		30. Name and address of person		-		eath (Iten	,	-				224				
		Theodore King MD.	Assist	tant Me	dical E	xamine	er 111 Pe	nn Stree	t, Bal	imore,	21 טוא	201				

State Registrar



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	State of Maryland / Department of Health and Mental Hyg	giene	nn
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			Registrer 1. Decedent's Name (First, Middle, Last)	Timeate of Death	Reg. 2. Date of Death	3. Time of Death
	Physici /Medic		Wayne	Tacy	March 2	$27, 2006 20:50 P^{M}$
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			2 Whitestone Ct.	Silver Spring If Under 1 Year If Under 24 Hrs.		Montgomery
	Funeral Director		5. Social Security Number 6. Sex 1. M 2 F 7. Age (In yrs. last birthda) 5. Sex 1. M 2 F 7. Age (In yrs. last birthda) 7. Age (Months Days Hours Min.	8. Date of Birth (Month, Day, Ye APR 21, 1	9. Birthplace (State or Foreign Country) Washington D(
	land w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location		10d. Inside City Limits
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NINISION (anding F sath. or: After he funer	atlon	27. Manner of Death Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how	injury occurred
Š	el or Att s after de ni Directo ed in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	itreet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, Itate)
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical (29a. Certifier (Checker) one) 1	ath occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			1 Hanforkouro	O.C.M.E.	Ma	rch 28, 2006
	5		30. Name and address of person who completed cause of death (Item 23a) (Type I Afon to the III P	enn Street, Baltimo	ore, Mary	land 21201
	Sta		31. Date filed (Month, Day, Year) MAR 3 0 2006	Analis		
	Registr	al	MAR 3 0 2006 Marie 15.			

V		1 - State Registrar Ce	artment of Health and Men	Reg. No. 1000 11090
Physi		1. Decedent's Name (First, Middle, Last) Robert Ivey TILLER, III		Date of Death Month Day Year Cch 28 2006 1:00 p M
Exam	dical niner	4a. Facility Name (If not institution, give street and number) 15605 Over View Circle	4b. City, Town, or Location of Death Hagerstown	4c. County of Death Washington
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 578-50-9163 1\overline{\text{NM}} & 2 \subseteq \text{F} 68 Yrs.	Months Days Hours Min. De	oate of Birth 9. Birthplace (State or Foreign Month, Day, Year) 22,1937 Wash.D.C.
e Maryland	ctor	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L Maryland Washington Hagers		10d. Inside City Limits 1 ☐ Yes 2 🏗 No
with the	Dire	10e. Street and Number 15605 Over View Circle	10f. Zip Code 21740	10g. Citizen of What Country? USA
DESIGNMENT PARTY STRUCT LATE 15-0030 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Iteme 23a or 28a-f show any injury or other treumatic event, the Madical Examinar must be notified at	by Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- 14. Race - American Indian,
within 72 hours and maturely, on Medical Example.	Completed	15. Decedent's Education (Specify only highest grade completed) (Giv life. Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) inspector	16b. Kind of Business/Industry
nand A uld be filled Mental Hygid Irked other	To Be Co	17. Father's Name (First, Middle, Last) Robert Ivey Tiller, Jr.	18. Mother's Name (Fir	st. Middle, Maiden Sumame) ona Grimley
MIGHTY and 2 sho alth and h 27 is ma			ling Address (Street and Number or Rural Ro O Fairview Rd., Hage	
Dalitimore Demit. Pages 1.2 Department of He mportant: If iten		4 Donation 5 Other (Specify) North F	ork Mem. Cem. 4/1/06	
Danit. Depermit. Depermit. Import.	S S S S S S S S S S S S S S S S S S S		22. Name and Address of Facility MINNIC 415 E. Wilson Blvd.,	
death certificate be executed Warding by sicten and dror use as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ensure that cause on each line. If mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Enforction esetes mellitus	Approximate Interval Between Onset and Death 8 - 10 50005
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
ords, F.O. requires thet the sen signed by th hould be deteche	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Frobabíy 4 Unknown
II KECOLGS, The law requires to the law seem signer, page 2 should be	Completed	Alcohol Abuse		24a. Was an autopsy performed? 1 Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death?
VITAI rsician: 1 s certificei director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 22 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Pface of Death (Cf	neck only one) 5 ☐ Residence 6 □ Other (Specify)
HON OT anding Phy ath. or: After this ne funeral d	ation: T		of 28c. Injury at 28d.	Describe how injury occurred
LIVISION (Itel or Attending F its efter death. el Director: After i led in by the funera	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
he Hospitel on 24 hours en Funerel C	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal of the best of my k	investigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s)
To the To the Comp	W	29b. Signature and title of certifier	29c. License number 0 - 0 5 5 6 4 1 3	29d. Date signed (Month, Day, Year)
H 11+1		30. Name and address of person who completed cause if death (Item 23a) (Type	a, Print)	of Not Mal 2174
Street, Street	State strar	31. Date filed (Month, Day, Year) MAR 3 1 2006 AR 3 1 2006	July	29d. Date signed (Month, Day, Year) 03/79/06 URT NAG. Mcl 2174

	1 - For State Regiatrar	State of Maryland		rtment of tificate of				giene Reg. No.	06	11696)
Dharaiaian	1. Decedent's Name (First, Middle, Last)					2.	Date of Dea	ath Day	Year	3. Time of Deat	th
Physician /Medical	Robert Paul	Taylor				I	March		2006	12:45	ΑМ
xaminer	4a. Facility Name (If not institution, give s	•		4b. City, Town,		of Death		4c. C	ounty of Death		
	Genesis HealthCa			La If Under 1 Yea	ston	Od Uro			Talbo		
eral ctor	5. Social Security Number 6. Sex 215-20-1602	7. Age (In yrs. last	Yrs.	Months Days		Min. M.	Date of Birt (Month, Day Jy 30, 1	h Y Year) O 26	Cou		eign
) i	Usual Residence of Decedent	17				1 (0	119 JO, 1	720	Mary	iland	
	10a. State 10b. County	10c. City, T	own or Loc	ation						IOd. Inside City Lin	nits
ctor	Maryland Talbot	7ra	ppe							1 ☐ Yes 2 ☐	No
Director	10e. Street and Number			10f. Zip Code			1	-	on of What Cou	,	,
62	29730 Bollingbroke			2167						s of Ame	ric
Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Yes, specify Cu	Hispanic Ori ban, Mexicai	rigin? (Specify n, Puerto Ric	y Yes or No- an, etc.)	- 14	Black, White,		
by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □NYes 2 □ No If Yes, Give Year or Dates:	1	□Yes 210MN	Specify:			S	pecify:	axian	
			6a Decede	ent's Usual Occi	upation				of Business/In		
Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	ind of work don O NOT use retir	e during mos ed)	st of working		Depa	rtment	of Natur	al
S	11 HS Grad		Par	rk Range	er			R	esource	<i>S</i>	
Be	17. Father's Name (First, Middle, Last)					er's Name (F		Maiden S	umame)		
မ					-	nnie D				24/7	¬ ·
	19a. Informant's Name/Relationship (Ty)									ocode) 2167 Paryland	3
	Ida Robertson Tayl			ition (Name of	jucone	Date			ation - City or To		
	1 Burial 2 Cremation 3 R	omough from State Cem	etery, crem	atory or other pi emetery	ace)	4/3/20			n, Mary		
	' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligense						112	Je ve	72 , 1162 cg	Curu	
	Douglohul No	YUL -		Name and Add				,	m	1 727	(1
	23a. Part1. Enter the discase, or compli	cations that caused the death. I	Do not ente	r the mode of dy	ing, such as	d Stre cardiac or re	et, Di	rest,	. Marye	and 2162 Approximate	
ı	shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	11	11		. 11	He lien	2		Interval Between Onset and eath	1
	disease or condition resulting in death)	Due to (or as a consequen	ice of):	a land	7 12011	29 11	7100	*		mang 125	_
	Cognosticity list conditions										
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ice of):								
Examiner	that initiated events resulting in death) Last	Dug to /or on a consequen									
		Due to (or as a consequen	ice or):								
dical											
/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	/					23	d. Date of delive	Pn/	
ciar	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal de 4 Pregnant at time of deat		Ectopic pregnan Other (specify)	су				Month	Day Year	
hysician/M	9 Unknown	9□ Unknown		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
by P	Part II. Other significant conditions cor	tributing to death but not resulting	ng in the un	derlying cause g	jiven in Part I	l,	23e. Did to	obacco use	e contribute to t	he cause of death?	?
		andiomy opet	1 -				1 🗆 Y	/es 2□	No 3☐ Prot	pably 4 Unknow	own
Completed			,			ĺ	24a. Was		24b. Were auto	ppsy findings availa	able
E O						_		rmed? 2 No	death?		0.
Be (25. Was case referred to medical				26. Place	e of Death (C		-			
P	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER	/Outpatient	3□ DOA C	ther: 4 No	ursing Home	5 🗆 Resid	dence 6 (□Other (Specif	<i>(y)</i>	
on:	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury		ork?	1	l. Describe h	now injury	occurred		
cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Diese of tall	· faces		_Yes 2□		Leastic - "	Pleast s : :	Alumber C	I Dout- M.	
Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office	9	28f.	Location (5 City or Tow		Number or Rura	al Route Number,	
		sician: To the best of my knowle	ndge death	occurred at the	time date or	nd place, and	due to the	called(s) a	nd manner as a	tated	
edical	(Check only 2 Medical Examination)	ner: On the basis of examination and manner stated.	and/or inv	estigation, in my	opinion, dea	ath occurred	at the time,	date and p	lace, and due to	o the cause(s)	
Me	29b. Signature and title of certifier	10 m			nse number				signed (Month,		
	1	Alrow /m			Di	2593	3	,	3.31.1	26	
	30 Name and address of person who co	mpleted cause of death (Item 23	3a) (Type, F	Print)		1		, -	100 1	260	,
	I'IICHAEL CROWL	LY, MD GI	0 Du	TCHMA	INS 1	LANE	L	9570	on, ITIL	2160	1_
State	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e face Mr.	B					,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year 4:04 A^M ERNEST M. VITALE MARCH 25,2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL 3301 POCAHONTAS DRIVE EDGEWATER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months 10 M 2□ F 84 OCT.21.1921 WASHINGTON D.C 577 22 0507 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☐ No MARYLAND ANNE ARUNDEL **EDGEWATER** 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 3301 POCAHONTAS DRIVE 21037 UNITED STATES 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 □ No
If Yes, Give
Year or Dates: 1944–46 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Specify: WHITE 1 ☐ Yes 2 ▼No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 AERONAUTICAL ENGINEER U.S. AIR FORCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MICHAEL VITALE FLORENCE BAILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN C. VITALE (SON) 1112 SAFFERON WAY OWINGS, MD. 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State A □ Donation 5 □ Other (Specify) 3-27-06 KALAS CREMATORY EDGEWATER, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME unio ull 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) We Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? rt I. 3 Probably 4 Dunknown 2 No 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

Works

rai', or items 23a or 28a-1 show Examiner must be notified at

traumatic event, the Medical

other

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Pages 1 and 2 should nent of Health and Men

permit. Page Department of Important: If any injury or

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the Maryland

within 72 hours after death with

Baltimore, Maryland 21215-0036

Examiner by Physician/Medical Completed

burial-tran led by the attending physician detached for use as the buria 8 page 2 has certificate this funeral Director: filled in by the

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Certification:

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27. N

The law requires that the death certificate be executed

To the Hospital or Attending

death.

after

within 24 hours a To the Funerei I

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown

25. Was case referred to medical examiner?

31. Date filed (Month, Day, Year)

4 Homicide

29a, Certifier

Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in Pa

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one Home 5 € Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Yes 2 X	No	1 ☐ Inpatient 2 ☐	J ER/Outpatient	3∐ DC	Α 4	4 ☐ Nursing
Manner of Death 1 XNatural 2 Accident	5 Pending investigation		28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes	2 □No
3 Suicide	6 Could not be	9 Don Diana of Inium. At h	ama farm stran	t factor	office	

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Other

29c. License number 29b. Signature and fitte of certifier

29d. Date signed (Month, Day, Year)

MARCH 27,2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ess of person who completed cause of death (Item 23a) (Type, Print) Name and add

Hospital:

State Registrar

MAR 2 8 2006



			For State Registrar	State of M	arylan		artment <i>tificate</i>			and M	_	giene Reg. Nö.	006	1169	98
П	Physicia	an	Decedent's Name (First, Middle, La	,							2. Date of De Month APRIL	ath 5 ^{Da})	, X995	3. Time of I	
	/Medic			ouise.		oland					APRIL			0900	М
	Examin	er	4a. Facility Name (If not institution, give MEMORIAL HOSPITA))		4b. City, T		Location o	f Death			County of Deat		
	- Francis		5. Social Security Number 6. S		ne (In vrs.	last birthday)	If Under 1		If Under 2	24 Hrs.	8. Date of Bir			thplace (State or	r Foreign
	Funeral Director			DM 2DE	77	Yrs.		Days	Hours	Min.	Jul 1,	1928	Co	MD	roreign
			Usual Residence of Decedent								our i,				
	ahow	<u>.</u>	PA Bedfor	d	10c. Cit	y, Town or Lo Artem								10d. Inside Cit	,
	Ba-f	Director		u		Aiteii								1 🗆 Yes	X I NO
	with t	吉	10e. Street and Number	. 1			10f. Zip (7211			10g. Citi	zen of What Co	ountry?	
	eath	Funerai	1436 Barnes Road	12. Was Decedent	Ever in II	S 13 V	Was Decede				acify Ves or No		USA 14. Race - Ame	arican Indian	
	riten	표	1 Never Married 2 Married	Armed Forces	?					, Puerto	ecify Yes or No Rican, etc.)		Black, Whit	te, etc.	
ğ	e since		3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:			∏Yes 2	No No	Specity:				Specify: wh	ite	
2	be filed within 72 hours after death with the Maryland all Hygiene. Id other than "natural", or items 23e or 28e-f ahow other than "natural", or items 23e or 28e-f ahow event, the Medical Examirant must be notified at	Completed by	15. Decedent's E. (Specify only highest gra	ducation ade completed)		16a. Deced	tent's Usual	Occupa	ition Jurina most	of work	ina	16b. K	nd of Business		
2	vithin ne. hen	ld m	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work DO NOT use	e retired,				O - h			
N	Hygi Ther nt, 1	ပိ	17. Father's Name (First, Middle, Last,	1		Bus D	river		18 Mothe	r's Name	e (First, Middle,	Sch			
ano		o Be	John McManis	•							Hess M				
Maryland 21215-0036	2 should be t and Mental I is marked of aumatic eve	ဥ	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address	(Street a	ind Numbe				r Town, State, a	Zip Code)	
	at 27		Edward Voland Sr	husb	and	1436	Barn	es F	Road		Arten		P		1
Je,	of Hea of Hea of Hea of Hear r other		20a. Method of Disposition			Place of Dispo	sition (Nami	e of her place	9)	ε	Date	20c. Lo	cation - City or	Town, State	
Ĕ	Pages nent of ant: if it any or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specil			view Ce		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			4/9/2006	Art	emas	PA	4
Baltimore,	permit. Page Dapartment Important: fi any injury or once.		21. Signature of Funeral Service Licer	isee / h /	111	- 22	. Name and	Addres	s of Facility	al Ho	me, PA				
	207 9 9		V/////////	TIW	001		108	Virgi	inia Av	enue	: Cumber	land,	MD 2150	2	
		٠.	23a. Part. Enter the disease, or com- spock, or heart failure. List only	plications that cause one cause on each	d the deat ine.	h. Do not ent	er the mode	of dying	j, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
Z	Physician		Immediate Cause (Final disease or condition resulting in death)	a Luna	Can	COL								2 URG	C3
	/Medical Examiner		Tooling in doubly	Due to (ar)	s a conseq	uence of):								. 0	
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o.	at the de by tha a	Physician/Me	1 Yes 2 No	4□Pregnant a 9□Unknown	it time of d	eath 5∟	Other (spe	ecify)						, .	
۹.	res that t igned by be detai		Part II. Other significent conditions of	contributing to death I	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did t	obacco u	se contribute to	the cause of de	eath?
ds	uires n sign ald be	d by									10	Yes 2	□No 3□Pi	robably 4 🔯	nknown
ပ	tw require s been sign should b	iete									24a. Was	an	24b. Were as	utopsy findings a	available
æ	The lay	Completed										rmed?	prior to death?	completion of ca	iuse of
a	nysician: Th nis certificate I director, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes	2 No ne)	1010	20110	
<u> </u>	Physic this ce al dire	To	1 ☐ Yes 2 ☑ No	Hospital:	ent 2	ER/Outpatien	t 3 DO	A Othe	^{0C:} 4 □ Nu	rsing Ho	me 5 ☐ Resi	dence	6 ☐Other (Spe	icity)	
ב	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury		C. Injury Work			28d. Describe	how infu	y occurred		
Sic	Attending Physician: r death. sctor: After this certific by the funeral director,	cat	2 Accident investigatio 3 Suicide 6 Could not b	e 50 51 41			М		/es 2 □ l	No	00(1)				
Division of Vital Records,	i or Attene aftar deatl Director: I in by the	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specif	y)	eet, tactory,	office			City or Tol	wn, State	d Number or Ri	ural Route Numb	<i>561</i> ,
_	To the Hospital or Attenwithin 24 hours aftar deat To the Funeral Director: completely filled in by the	Ö	29a. Certifier 1 ☐ Certifying Pt	ysicien: To the best	of my kno	wledge, death	occurred a	t the tim	e. date an	d place	and due to the	Cause(e)	and manner as	s stated	
	ne Ho ne Fui iletely	edicai	(Check only 2 Medical Example)	miner: On the basis of and manner s	of examina	tion and/or in	vestigation,	in my op	ninion, deal	th occurr	ed at the time,	date and	place, and due	to the cause(s))
	To the within To the Comp	Me	29b. Signature and title of certifier	11-		~	29c.	License	number				te signed (Mont	-	
			///	My			Γ	367	66			APR.	IL 6 20	06	
	5		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)	7.7	D 21E	02					
				924 SETON	DRTV.	E CUMBI	LKLANI), M	n 712	UZ					
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2	2006 ^{32. Regist}	rars Signa	iture .									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:37A M WILLIAMS M. 06 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Annapolis Anne Arundel ANNE ARUNDEL MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Year)

Jan 10 19 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 10 M 2 214-66-1078 1954 D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Anne Arundel Annapolis 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1120 Madison St. Apt A2 21403 TISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status XXNever Married 2 Married 1 ☐ Yes XXNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Colfege (1-4or 5+) Elementary/Secondary (0-12) Server Naval Academy 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Moncil Williams Lavalette Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772. 19a. Informant's Name/Relationship (Type, Print) Beverly Johnson(Sister) 6114 Croom Station Rd. Upper Marlboro, Md. 20b. Place of Disposition (Name of Beanetelyactereto) Promongo 20 1 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3-31-06 Park Annapolis, Md. 4 □ Donation 5 □ Other (Specify) Wm. Reese & Sons Mortuary, 821 West St. Annapolis, Md. 21. Signature of Funeral Service Licensee 17. Deese MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUDDEN CARDIAC DEATH (ARRHYTHMIA disease or condition resulting in death) Due to (or as a consequence of): CARDIOMYOPATHY , SECONDARY Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ABUSE ALCOHOL that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SYSTEMIC LUPUS ERVIHEMATOSIS 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 Yes 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ZIVNO 2 R/Outpatient 3 DOA 28d. Describe how injury occurred

/Medical Examiner Examiner physician and s the burial-transit Physician/Medical þ Certification: death.

Physician

/Medical

Examiner

Funeral

Director

rthan "naturst", or itsma 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked othe any linky or other traumatic event pixe.

Physician

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Vital of Division the Hospitel or Attending Director: within 24 hours after or To the Funerel Direct completely filled in by

GASTRIC BYPAS 25. Was case referred to medical examiner? 1 Tyes 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28b. Time of Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifie (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and itle of certifier natoro 29c. License number D 41034

29d. Date signed (Month, Day, Year) March 25, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 300 ANNAPOLIS

128 LUBRAND 31. Date filed (Month, Day, Year)

32. F gistrar's Signature MAR 2 9 2006

of auria, un)

Registrar

			1 - For State Registrar	State o	f Maryla	and / Depa	artmen					jiene eg. No. U	0.6	
			Decedent's Name (First, Middle, L.	ast)						2.	Date of Deat	th	-	3. Time of Death
	Physici: /Medic		Arlene Dorothy We	eightman							Month Irch 29	9, 2006	Year	11:33 p ^M
	Examin		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City,	Town, or	Location o			·	inty of Death	
			Charles County Nu	rsing &	Rehab		LaP:					Cha	arles	
	Funeral			Sex 1 □ M 2 □ X F	7. Age (In y	rs. last birthday)	If Under Months	1 Year Days	If Under :	Min.	Date of Birth (Month, Day,	, Year)	Cou	place (State or Foreign intry)
	Director		579-30-2722 Usual Residence of Decedent	-41		Yrs.				Ap	oril 2	1,1925	5 Ver	mont
	/land		10a. State 10b. County		10c.	City, Town or Lo	cation							10d. Inside City Limits
	Many P-f sh	to	Maryland Charles	;	I	ndian He	ead							1XYes 2□No
	or 28g	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Cou	intry?
	th wil	alD	1 Beth Court				20	0640				U.S.	Α.	
	tems	Funeral	11. Marital Status	12. Was Deci	rces?	n U.S. 13.	Was Deced	lent of Hi	ispanic Orig	gin? (Specify i, Puerto Rica	Yes or No-		Race - Ameri Black, White,	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gir			1 □ Yes		Specify:				ocify: Whi	
o	turel	ed t	15. Decedent's	Year or D	a (es:	16a Dece	dent's Usua	d Occupa	ation				MN1 f Business/ir	
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2	d with	Completed	8	College (1-401 5+7	Admin	nistra	ativ	e Sup	ervisc	or	Food	& Agr	iculture
nd	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or Items 23a or 28a-f show event, the Marical Evaint actional be redilled at	Be (17. Father's Name (First, Middle, Las	st)					18. Mothe	er's Name (Fil	rst, Middle, I			
yla	Suld by Ment arked	10		emnah					Ril			lls		
Jar	2 shoot and ls m		19a. Informant's Name/Relationship	(Type, Print)						er or Rural Ro		, City or Tox	wn, State, Zij	o Code)
e,	1 and 1eelth sm 27 ther t		Diane Lobaugh 20a. Method of Disposition		201	880	Lowel.	L Rd	., Po	mfret,	Md.	20675		-
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "naturel, or Items 23a or 28a-f show eny injury or other treumetic event, the Medical Evantical Internative Inclined at 2002.		1 ☑ Burial 2 ☐ Cremation 3		State	ashingto	natory or o	ther plac	e) Apri	1 4. 2	006		on - City or T	
턡	artme ortent injury	. 4	` 4 Donation 5 Other (Spec 21. Signature of Funeral Service Lic		l W		on Nat 2. Name an					Suitla	and, M	aryland
Ba	Depar Impo		12-121		M006	60 1	Villia	ams]	Funer	al Hom	e, P.A	<i>A</i> .		
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	/Medical		disease or condition resulting in death)	aDue to		sequence of):		(7 13 (na				700
П	Examiner		Sequentially list conditions.	b			_	_						
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687	ficate p phy: ss the	edlo		d										
Вох	eath certific attending p for use as	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			7-					23d.	Date of deliv	ery
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<u>Ф</u>	that the de led by the a detached t	Physician/Me	9 🗌 Unknown	9Ll Unkno										
	es Ded	by	Part II. Other significant conditions	contributing to de	eath but not	resulting in the u	nderlying ca	ause give	en in Part I.			_		he cause of death?
ord	v requir been si should	sted									1 □ Ye	s 2∐No	3 🗌 Prot	bably 4 Unknown
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											perform	ned?/ 2□No	death? 1 ☐ Yes	2 🗆 No
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ō	문 등 교	1: To	1 Yes 2 No 27. Manner of Leath	28a. Date		28b. Time of		8c. Injury	4 Nul	rsing Home	5 Reside			fy)
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ā	tel or A s after el Dire ed in by	Certification;	4 - Homede	Duildi	ng, etc. (Spe	эсту)				1	City or Town	i, State)		
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(27		30. Name and address of person who	Completed caus	e of death (I	tem 23a) (Type,	Print)	-	1)	1010	1/1	\ In	2/11/1
	Sta	to	31. Date filed (Month, Day, Year)	4 7V	eg firar's Si	anature O	14 1	12	(01)	, p~	UVA	1001	Jv	a wool
	Registr		MAR'3	0 2006	Holes	J. J.	book	20						

	4.5		1 - For State Registrar	State of M	laryland / De	partmer ertificat			Men		giene	006	70
	Dhuaiai		1. Decedent's Name (First, Middle, La	st)						Date of Dea Month	th Day	Year	3, Time of Death
	Physici /Medic		William Frankli	n Wright				·		03	29	2006	11:25A M
	Examin	er	4a. Facility Name (If not institution, giv			4b. City,	Town, or	Location of De	ath			County of Dea	
	*	26-5	Future Care (stown				altim	
in the second	Funeral Director		5. Social Security Number 6. S 224-24-1484 Usual Residence of Decedent	ex 7. A	ge (In yrs. last birthd 80 Yrs	Months	Days	Hours M	in.	Date of Birth Month, Day 0/14			rthplace (State or Foreign ountry) A
	land		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	f sh	ğ	MD Baltim	ore	Upperco	O							1 ☐ Yes 2 # No
	1 the	Funeral Director	10e. Street and Number			10f. Zi	o Code				10g. Citiz	en of What C	ountry?
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003	72 hours after death with the Maryland natural; or teme 23a or 28a-f show iteal Evand at must be podified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates	1943-1946		204140	ороспу.				Specify: VV II	
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d 21	Hygid ther	ပို	17. Father's Name (First, Middle, Last	1	10	- Cinaii		18. Mother's N	lame (Fir			ufact	urriig
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	alth a	9	Dorothy Marie W	Wright W				nover			-		21155
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E	Page lent c nt: if ry or		1		Holly H				2006 :il 3		Midd	lle Riv	er, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show eny injury or other traumatic event, It a Medical Examinat must be notified at once.		21. Signature of Funeral Service Lice	nsee	1	22. Name a				Fune			
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	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com sook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a c.	s a consequence of): s a consequence of): s a consequence of):						Chi	f .	Approximate interval Between Oaser and Death Oaser and Death Crimbury
760,	cien cien buria	ical E		Due to (or a	s a consequence or).								
•	physicate the l			_ d									
.O. Box 6	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death	3 □Ectopic p 5 □ Other (s _i					2	3d. Date of de Month	blivery Day Year
Records, P.	Se Co		Part II. Other significant conditions of	contributing to death	but not resulting in th	e underlying (cause give	en in Part I.			bacco us		o the cause of death?
CO	w require been si should I	Completed	De	nentro	•				_	24a. Was a	an	24h Were a	utopsy findings available
Re	9 2 9	Ë			,				-	autop perfor	sy med?	prior to death?	completion of cause of
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<u>></u>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	tient 2 ER/Outpa	tient 3 D	OA Othe	Nr				□Other (Spe	acity)
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Division	Attending r death.	Certification:	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigatio	n	ay roar, Inju	м		Yes 2 □No					
ivis	or Atte	ŧ,	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I	njury - At home, farm, etc. (Specify)	street, factor	y, office			Location (S City or Tow			Rural Route Number.
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	MZ	2	20 November 1		/		()6	7300	7	T. 10 . 10	e w	Same A	AIA
	6		30. Name and address of person who	completed suse of	geath (Item 23a) (Ty	pe, Print)	K3	300/21	20-	o Ti	ree	ARYLA	21208
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	Registi	ar	MAR 3 1	2006	com te	1	9						

			1 - For Stata Registrar	State of M	aryland / De		of H	ealth a	and M	ental Hy	giene Reg. No.	egible. 006	11702
	Physici	an	 Decedent's Name (First, Middle, Last, Chang Hwan Wee 							2. Date of De Month March		2006 Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give	otroot and number		4b. City, To	uwn or	Location	of Doath	Harch	1	County of Dea	5:45 a M
100	Examir	ner	Washington Adven					na Pai				ontgome	
	Funeral Director		5. Social Security Number 6. Sec	*	e (In yrs. last birtho	ay) If Under 1	Year	If Under : Hours		8. Date of Bi (Month, Da Jan. 1	rth av. Year)	9. Bii	nthplace (State or Foreign ountry)
	P _		Usual Residence of Decedent		1.5 - 2.5								
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	with ti	Ē	10e. Street and Number			10f. Zip Co					10g. Citiz	en of What C	ountry?
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Baltimore,	ages 1 a ant of Hea it: if itam y or othe		20a. Method of Disposition 1 ☑SBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Documetery, Gate of He	crematory or othe	er plac	11.14	arch	29,		eation - City of	rTown, State ing, Marylan
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	w requires that the been signed by th should be detache	ed by	Part II. Other significant conditions con Abdominal Aortic				se give	an in Part I.					to the cause of death?
Il Records,	The law rate has be page 2 sh	Complet	Cholelithiasis, C	holedocho	olithiasis					24a. Was auto perfe 1 Tyes	psy ormed?	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 \(\) No
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	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best ner: On the basis of and manner st	of examination and/o	eath occurred at r investigation, in	the tin	ne, date an pinion, deal	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the To the Company of the Company	Σ	29b. Signature and title of contifier	Sunfi	i i			707				signed (Mon h 28,	th, Day, Year) 2006
	10		30. Name and address of person who can Sung B. Kim, M. D.		death (Item 23a) (Ty Carroll Av		270	, Tak	oma	Park,	MD 20	912	

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) MAR 2 9

ORIGINAL

32. Registrar's Signature

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey Year WEBER 2006 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street end number) SHADY GROVE MONTGOMERY ADVENTIST HOSPITAL KOCKVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthdey) Days Min NONE 1**Д** М 2□ F Yrs. Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2□ No MARYLAND MONTGOMERY 10g. Citizen of What Country? 10e. Street end Number EXETER USA 20814 7006 Was Decedent of Hispenic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces?, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INFAN7 B 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Neme (First, Middle, Lest) BIRBAUMER CORNELIA 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROAD, BETHESDA. MD 20814 EXETER 7006 MOTHER CORNELIA WEBER 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) STERI HALL RIVER, NC CYCLE 05-05-06 22. Name end Address of Facility 21. Signature of Funeral Service Licensee HVENTIST HOSPILAL GROVE ased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ch line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) prematurity Due to (or as e consequence of) Due to (or as e consequence of): Due to (or as e consequenca of): Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No 1 Tyes 25. Wes case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

sete has been signed by the attending physicien end page 2 should be detached for use es the burial-trensit

certificate

this

erei Director: After this fillad in by the funeral

within 24 hours e'

director,

or Attending Physician: The law raquiras thet the daath certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician/Medicai Examine

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Completed

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Certification:

edical

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Physician

/Medical

Examiner

Funeral Director

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Completed

Funeral

Director

death with the Marylend

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryle Depentiment of Health end Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tra Medical Examiner must be notified at educa.

altimore, Maryland 21215-0036

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. [
N N N N N N N N N N N N N N N N N N N	1 1

24a. Was en auto performed?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient

28b. Time of Injury 28c. Injury at Work? 27. Menner of Deeth 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier

29d. Date signed (Month, Day, Year) 29b. Signature end title of Pertifier 29c. License number

Doman 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850 Zuckerman 31. Date filed (Month, Day, Year)
APR 1 3 2006

State Registrar

		1 - For State Registrar	State o	f Maryland / Dep		of Health			iene () () 6	1704
*		1. Decedent's Name (First, Middle, L	.ast)					2. Date of Deat Month	h Day Year	3. Time of Death
Physicia /Medic		Larry Dean Wea	ver					March	30 2006	2-30 PM
Examin		4a. Facility Name (If not institution, g		mber)	4b. City, T	own, or Locatio	n of Death		4c. County of Dea	th
		11102 Lakeview	Drive			Hagerst	own_		Washingto	n County
Funeral		Social Security Number 6.	Sex 1X M 2□F	7. Age (In yrs. last birthda	y) If Under 1 Months	Year If Und	er 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State of Foreign
Director		218-60-0639	IAIM ZUF	54 Yrs.				Jan 17		yland
and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	Location					10d, Inside City Limits
/ary/	5	M333-1-1-1-1-1-1-1-1-1-1-1-1-1								1 □ Yes 2 V No
ith the Marylan or 28e-f show	ect	Maryland Washi	ngton	нао	erstowr 10f. Zip (10	ng. Citizen of What Co	
with a or	ā		D . !		TOI. Elp (10	,		ountry:
eath na 23	erai	11102 Lakeview		edent Ever in U.S. 13	Was Decede	2174		acify Yes or No.	U.S.A.	arican Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural, or items 23s or 28s-1 show appringury or other traumatic event, the Medical Exeminar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo 1X Yes If Yes, Giv	2 No	If Yes, specif			ecify Yes or No- Rican, etc.)	Black, Whi	
hour hour	De la		Year or D		edent's Usual	Occupation			16b. Kind of Business	Andreater
21215-0036 ad within 72 hours aft giene. or then "natural", or then "natural", or the Medical Exemi	Completed	15. Decedent's (Specify only highest of	rade completed)	(Gi	re kind of work	done during m	ost of worki	ng	ibb. Kind of business	rindustry
withi within	щć	Elementary/Secondary (0-12)	College (1	-4or 5+)		,				
d 2 filed Hygin ther	Ö	17. Father's Name (First, Middle, Las	st) 2	Admi	nistrat	ive Spe	CIALI	St (First, Middle, N	Federal G	overnment
d be antak	o Be	John Weaver				Ef	fie A	lice Fos	ster Weave	r
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth	Ţ	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ilina Address /	Street and Num	ber or Rura	I Poute Number.	City or Town, State,	Zip Code)
Ma id 2 s ith ar ith ar trau			ia 83	500	8.553 FR					
e, 1 an Heal	1	Roberta Lynn Woa' 20a. Method of Disposition	ver (with	20b. Place of Dis	DOSITION (Name	VIEW DI	rive H	agersto	on Marylan Oc. Location - City or	d 21/40 Town, State
Baltimore, bernit. Pages 1 ar bepartment of Hea mportant: if Item: iny injury or other ince.		1 Burial 2X Cremation 3		State		1	1 1			
Itin	i	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Smithsb		Address of Fac			Smithsburg	
Ba Dermi Depa impo		21. Signature of Pulleral Service Lic	1/				. 10	_	_	enral Home
- 45.200		/ / Junges	ZY. Y							yland 21742
		23a. Part1. Enter the disease, of co shock, or heart failure. List on	ly one cause on e	ach line.	nter the mode	or aying, such a	as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Al2	heimers	Q-15e	ase				4 years
/Medical Examiner		resulting in death)	Due to (or as a consequence of):						
Examine		Sequentially list conditions,	b							
D #	inel	cause. Enter Underlying Cause (Disease or injury	Due to (or as a sonsequents of):						
8760, ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c.							
760, te be exergiscian a purial.		resulting in deathly East	Due to (or as a consequence of):						
876 ate b hysic the b	licai	•	d.							
9 # 6 8	Physician/Med	IF FEMALE:								
Box eath cert attending for use a	an/I	23b. Was decedent pregnant in the past 12 months?		come of pregnancy irth 2 D Fetal death 3	□Ectopic pre	gnancy			23d. Date of de Month	•
O. E.	sici	1 ☐ Yes 2 ☐ No	4□Pregn 9□Unkno		Other (spe	city)			MOUTH	Day Year
P.O. that the de ed by the detached	h	9 Unknown								
IS, P	by	Part II. Other significant conditions	contributing to de	eath but not resulting in the	underlying car	use given in Par	t I.		acco use contribute to	
cord w require been si								1 ☐ Ye	s 2.12 No 3.□Pi	obably 4 Unknown
Division of Vital Records, or attending Physicien: The law requires that of each. Director: Atter this certificate has been signed in by the funeral director, page 2 should be each.	Completed							24a. Was ar	24b. Were a	utopsy findings available completion of cause of
The The sage	E O							perform	led death?	
ital	Be C	25. Was case referred to medical				26. Pla	ce of Death	(Check only one		
on of Vital Red ding Physicien: The lav h. Atter this certificate has funeral director, page 2	ToB	examiner? 1 ☐ Yes 2 █️No	Hospital: 1 🗆 I	npatient 2 ER/Outpat	ent 3 DOA	Cthor			nce 6 Other (Spe	cifv)
g Ph er th		27. Manner of Death	28a. Date of	of Injury 28b. Time	of 28	c. Injury at Work?			w injury occurred	
indin all or	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		h, Day Year) Injury	М	1 Yes 2	□No			
VISIO Attendi r death. ector: A by the fu	ific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	288. Place	of Injury - At home, farm,	street, factory,	office	2	28f. Location (Str	eet and Number or R	ural Route Number,
Div	ert	4 🗆 Homolog	bullali	ng, etc. (Specify)				City or Town	, State)	
Division To the Hospital or Attent within 24 hours after deall To the Funeral Director:		29a. Certifier 1 Certifying I	Physician: To the	best of my knowledge, de asis of examination and/or	ath occurred a	t the time, date	and place, a	and due to the ca	use(s) and manner as	s stated.
he H in 24 he Fi plete	Medicai	one)	and manr	ner stated.	investigation, i	n my opinion, a	eath occurr	ed at the time, da	ite and place, and du	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	,			License numbe			d. Date signed (Mont	
		Houn M	1		L	0050	1807	/	March 31,	2006
_		30. Name and address of person wh	o completed caus	e of death (Item 23a) (Typ	e, Print)					
05H-9+1		Samir Mir 11110	Medical	Campus Rd. 1	łagerst	own Mar	yland	21742		
Sta		31. Date filed (Month, Day, Year)		egistrar's Signature	1 .					
Registr	ar .	MAR 31	2006	Eren D. p	parket					

		1 - For State Registrar	State of Marylar		artment of		and Me		iene)6	11705
, s	:	Decedent's Name (First, Middle, Last)					2	2. Date of Dear		Year	3. Time of Death
Physic /Med		Nancy Murray Wate	rs					March	28 2	006	10:40 A M
Exam	iner	4a. Facility Name (If not institution, give s			4b. City, Town				4c. County		
Funera		Genesis College Vi		last birthday)	Fro	ederic		B. Date of Birth (Month, Day		9. Birth	County place (State or Foreign
Funera Directo	`	033-20-6384	M 2 XF 7		Months Day	s Hours		Jan 6	1929	Cou	sachusetts
pur *	.1	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation						I0d. Inside City Limits
Maryla f sho	for	Maryland Frederi		rederio							Yes 2 □ No
h the	rec	10e. Street and Number			10f. Zip Code	15		1	0g. Citizen of	What Cou	ntry?
23a o	Funeral Directo	700 Tollhouse Av	enue			21701			U	.S.A.	
er des items	nue	Tr. Maria Jacob	2. Was Decedent Ever in t Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Orig Jban, Mexican	gin? (Speci n, Puerto Ri	fy Yes or No- ican, etc.)		e - Ameri ck, White,	can Indian, etc.
JSD urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:		1□Yes 2 <mark>X</mark> N	o Specify:			Specif	v: Whi	.te
ING 21213-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or items 23a or 28a-f show event, the Medical Exam, an minist se notified at	Completed	15. Decedent's Educ			dent's Usual Occ kind of work dor		t of working	,	16b. Kind of B	usiness/In	dustry
Mithin New Yell	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)			n 1 1		, ,
C Z1Z1	S	17. Father's Name (First, Middle, Last)	5+	Tea	cher	18. Mothe	er's Name (First, Middle,	Publ: Maiden Sumar		:noo1
should be nd Mental marked o	To Be	James J. Murray				Ar	nne Lo	ouise G	arvin		
Maryland 21215-UU35 nd 2 should be filed within 72 hours at lith and Mental Hygiene. 27 Is marked other than "natural", or reaumatic event, the Mudical Exert		19a. Informant's Name/Relationship (Typ			ng Address (Stre	et and Numbe	er or Rural i	Route Number	, City or Town		
e, N 1 and 2 Health 1 mm 27 in tra		Joan Waters (daug			Farmho	use Dri					
2 2 2 2 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify))	cemetery, crei	natory or other p		Da		20c. Location		
baltimo		4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License			rd's Cei	100					sachusetts ral Home
		Dunch	FXIM					-			
	17	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.									
Physician		Immediate Cause (Final disease or condition	Demen	tia							Onset and Death
/Medica Examine		resulting in death)	Due to (or as a conse		1-32						
	e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as a conse		known o	rigin					
cuted	Examiner	that initiated events C.									
50, se exe cian ar urial-t	I Ex	resulting in death) Last	Due to (or as a conse	quence of):							
58760, icate be executed physician and s the burial-transit	dical	d									
ecords, P.O. Box 68/6U, law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregr						23d. Da	te of deliv	ery
death death add for	sicia	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnar Other (specify)				Mo	onth	Day Year
that the de	Phy	9 ☐ Unknown Part II. Other significant conditions con		aulting is the	ndarhing agusa	ausa in Dart I		23e Did to	hacca uso con	idhuta ta t	he cause of death?
dS, Fuires that signed dise del	d by	Partiti. Other significant conditions con	tributing to death but not re	suiting in the u	noerlying cause	giveri in Fanti.					pably 4 [XUnknown
Vital Records, ician: The law requires t certificate has been signe rector, page 2 should be	Completed							24a. Was a			opsy findings available
of Vital Rec hysician: The law his certificate has I director, page 2 s	omp							autops perfori	med?	prior to co death?	mpletion of cause of 2□ No
ian: ian:	BeC	25. Was case referred to medical examiner?				26. Place	of Death	Check only or	21	163	2010
	10	1 ☐ Yes 2XX No		ER/Outpatier	IL JU DOA				ence 6 □Oth		(y)
ding P	tlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	juryat /ork? ∐Yes 2 ⊡ l		ld. Describe h	ow injury occur	red	
Division of lor Attending Phy- after death. Director: After this lin by the funeral d	ifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I							er or Run	al Route Number,
DIVI	Certification:	4 Homicide	building, etc. (Spec	ıry)				City or Tow	n, State)		
DIV: To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	edical	29a. Certifier (Check only one) 157 Certifying Physical Examination (Check only one)	ician: To the best of my kner: On the basis of examinand manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in m	time, date an y opinion, dea	d place, an th occurred	d due to the c d at the time, d	ause(s) and make,	anner as s and due t	tated. o the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lice	nse number		2	9d. Date signe	d (Month,	Day, Year)
		Iver			DO	0060417	7		March	28,	2006
		30. Name and address of person who co			,						
H-12	tate	Hemen Shah MD 65	-E Thomas Jol 32. Registrar's Sign	nson D	r. Frede	rick M	Maryla	ınd 217	02		
Regis		Hemen Shah MD 65: 31. Date filed (Month, Day, Year)	96 June		reide						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stete Registrer	State of Ma	aryland / Depa	artment of H			Hygien Reg. No		11706
<i>3</i> (:	Physici	an	Decedent's Name (First, Midd					2. Date of Month		ay Year	3. Time of Death
	/Medic		Betty	Catherine	Wall			Mar			3:30 p ^M
4	Examin	er	4a. Facility Name (If not institution			4b. City, Town, or		of Death	40	. County of Death	
	4 · 184		The Annapoli			Annapol If Under 1 Year	Lis If Under	24 Hrs. G. D.	(8)	Anne Aru	
E	Funeral		5. Social Security Number 214–26–3463		e (In yrs. last birthday) 71 Yrs.	Months Days	Hours	Min. Feb	f Birth Year 193	O Ann	place (State or Foreign intry) apolis, MD
	Director		Usual Residence of Decedent	7111	-			100.2	.0,173	O AIIII	aports, MD
	/land		10a. State 10b. County	,	10c. City, Town or Lo	ocation					10d. Inside City Limits
	Man	ţō	Maryland Anne	Arundel	Annapol:	is					¹XX es 2□No
	r 288	Director	10e. Street and Number		_	10f. Zip Code			10g. C	itizen of What Cou	intry?
	h witi	Q E	150 South Stre	et		21401			Uni	ted Stat	es
	72 hours after death with the Maryland neturel', or Items 23s or 28s-f ehow dicel Exacilizations Le collited at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Ori	igin? (Specify Yes on, Puerto Rican, etc	r No-	14. Race - Amer	
တ္	or Ite	F	1 Never Married 2 Mar	ned 1 ☐ Yes 2 🛣 N	No I	1 ☐ Yes 2 X No	Specify:		"	Black, White	
8	irel'.	d by	3 XXvidowed 4 □ Divorce	If Yes, Give Year or Dates:			Opecity.			Specify: B1	ack
7	72 h	Completed		nt's Education est grade completed)	(Give	dent's Usual Occupa kind of work done of	during mos	st of working	16b. F	Kind of Business/li	ndustry
5	within ene. then	d d	Elementary/Secondary (0-12)	College (1-4or 5	+)	DO NOT use retired	3)		- 1		
7	a filed within al Hygiene. other than		12 17. Father's Name (First, Middle,	l ast)	Teacne	ers Aid	18 Mothe	er's Name (First, Mi		ucation	
and	dental h	Be	Allen E. John					ice Harri		(Sumame)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. If man 27 is marked other than "neturel", or Items 23a or 28a-f ehow other traumatic event, if a Mudical Exactlinar install the rightling at	ြ	19a, Informant's Name/Relation		19h Maili	ng Address (Street		er or Rural Route N		or Town State 7	in Codel
Ma	od 2 s lith an 27 is r		Marva Gaither/			0x 344 Sex				or rown, State, 21	p code)
o,	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition		20b. Place of Dispo cemetery, cre-			Date	-	ocation - City or T	own, State
10	nt of nt of t: If it		1XXBurial 2 Cremation		1			2 27 2007			
Baltimore,	it. P.		4 □ Donation 5 □ Other (S		Maryland	Nat. Cem 2. Name and Addres		3-27-2006	La	urel, MD	
Ba	Department of the partment of		21. Signatus of Full et al Salvice	(Lon-	2.	Hardesty	Fune	ral Home	P.A.		
			23a. Part 1. Enter the disease, o	r complications that caused	the death. Do not en	12 Ridge	ly Av	zenue, Ani	napoli	s, MD 21	401 Approximate
			shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each lin	10.	·	· 9,		.,		Interval Between Onset and Death
E.	Physician /Medical		disease or condition resulting in death)	a	CHEX	17					
20	Examiner			A Due to (or as	a consequence of):	2 A					
		-	Sequentially list conditions, if any, leading to immediate	b. 7 170 O	a consequence of):						
	ted nsit	Examiner	Cause (Disease or injury	< 21C	POEC	210 A	}				
	be executed icien and burial-transit	ха	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):	,,,	4			-	
8760,	icate be executed physicien and s the burial-transit	calE									
687	ficate physis the			0							
Вох	death certifica e attending ph id for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of delik	very
m	death a atte d for	cla	in the past 12 months? 1 Yes 2 No	1 Live birth 4 Pregnant at		∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>	′		_	Month	Day Year
о О	the y th	hys	9 Unknown	9□ Unknown							
	law requires that as been signed b 2 should be dete	by P	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the u	inderlying cause give	en in Part I	1. 23e. 1	Did tobacco	use contribute to	the cause of death?
Į,	quire n sig uld b								I□Yes }	No 3□Pro	bably 4 Unknown
Records,	aw requir ts been si 2 should l	Completed						24a. ¹	Masan	24b. Were aut	opsy findings available
Re	The lav	E							erformed?	death?	ompletion of cause of
_	ician: T certificat rector, pi	O	25. Was case referred to medica	Al I			26 Place	1 ☐ Y e of Death (Check o		o 1 ☐ Yes	2 No
5	Physician: this certific ral director,	OB	examiner? 1 ☐ Yes 2 X No	Hospital:	int 2 ER/Outpatie	nt 3 DOA Othe		ursing Home 5		6 Other (Spec	m 557 1-1 V
		L:	27. Manner of Death	28a. Date of Inju	ry 28b. Time o					ry occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ion	Attending r death. ector: After y the fune	atlo	1 Natural 5 Pendi 2 Accident invest	ng (Month, Da) igation	y Year) Injury		k? Yes 2□	No			
Division	after death after death Director:	III C	3 Suicide 6 Could 4 Homicide determ	nined 288. Place of Inju	ury - At home, farm, st	reet, factory, office		28f. Locati	on (Street a	nd Number or Rui	ral Route Number,
ā	s afte	Certification:	4 - Homicide	building, etc	с. (Зреспу)			Chy o	Town, Stat	θ)	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier Certifyi	ng Physician: To the best	of my knowledge, deat	h occurred at the tin	ne, date an	nd place, and due to	the cause(s	s) and manner as	stated.
	he He n 24 he Fu	edical	one)	Exeminer: On the basis of and manner sta	examination and/or in	vestigation, in my of	pinion, dea	ath occurred at the t	me, date an	id place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certific	er ()		29c. License	e number	0 /	29d. Da	ate signed (Month	Day, Year)
			fru	10 min	- M-1) DO	06	3145		3/17	106
			30. Name and address of person	who completed cause of d	eath (ftem 23a) (Type,	Print)					
				Desai, MD		ler Road	, Gle	n Burnie,	MD 21	1060	
	Sta		31. Date filed (Month, Day, Year		ar's Signature	AC .					
10	Registr	ar	MAR 28	LUUO Miller	D. Asse						

				State of Maryland						egible.	t t9 2	0.77
		•	For State Registrar	,		tificate of			Reg. No.	JUb		JI
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of	
	Physicia /Medic	_	Lena Mae Windsor					March	23		4:00	P M
	Examin		4a. Facility Name (If not institution, give s				r Location of Death	1		County of Death		
			Genesis Eldercare	<u> </u>	h da imble selec e l	Annapol If Under 1 Year		8. Date of Birt		nne Arur		r Foreign
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	Feb. 27	y, Year)	29 Missi	place (State o	
	Director	1	218-26-6518 Usual Residence of Decedent	111				FED. 21	, 19.			
	yland		10a. State 10b. County	10c. City, T	own or Lo	ocation					10d. Inside Ci 1 ☐ Yes	
	a-f e	cto	Maryland Anne Aru	ndel	Ar	napolis						- MI40
	ith th	Director	10e. Street and Number	0.1.4		10f. Zip Code			_	en of What Cou		
	within 72 hours atter death with the Maryland ene. than "naturel", or Items 23e or 28e-f ehow he Medical Examiner hinki be notified at		130 Hearne Drive A	pt. 914 2. Was Decedent Ever in U.S.	12	21401	lienanic Origin? (S			ed State		
	ltem Item	Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married	Armed Forces? 1 Yes 2 No	13.	Was Decedent of H If Yes, specify Cubi	an, Mexican, Puert	o Rican, etc.)		Black, White,	etc.	
36	irs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			Specify: Whi	ite	
21215-0036	2 hou		15. Decedent's Educ	ation 1	I6a. Dece	dent's Usual Occup	ation during most of wor	kina	16b. Kin	nd of Business/Ir	ndustry	
215	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)					
21	filed with Hygiene. other ther	Co	12			Cler	k 18. Mother's Nar	on (First Middle		, Postal	L Servi	<u>lce</u>
<u>n</u>	be fill H off	Be	17. Father's Name (First, Middle, Last)				Mary Agr					
7	2 should be t and Mental H le marked of raumatic ever	ဥ	Robert Lee Carr 19a. Informant's Name/Relationship (Type	na Print)	19b Maili	ng Address (Street					p Code)	
Maryland	d 2 si th and 7 ler traur		Stanley Windsor /			learne Dr		914	Anna	Town, State, Zi	Marylar	21401 id
	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or liems 23s or 28s-1 show any injury or other traumatic event, the Madical Exemples many be notified at once.		20a. Method of Disposition		e of Dispe	osition (Name of matory or other pla	cel	Date	20c. Loc	cation - City or T	own, State	
Baltimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 🌠 Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		coln Crem	1 1/2	25/2006	Bren	twood, 1	Mary lar	ıd
Ħ	mit. Foortan		21. Signature of Funeral Service License			2. Name and Addre						
Ö	Depare Important in any ir		1 Moderal ()	-	14	7 Duke o	f Glouces	ster St.	Anı	napolis	, MD 21	401
**	Physician /Medical Examiner	ılner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent of the to (or a) consequent of the to (or a) consequent of the (or a)	as	r dix	Lade					
8760,	ate be executed hysician and the burial-transit	lical Examiner	that intiated events resulting in death) Last	Due to (or as a consequer	nce of):							
.O. Box 68	law requires that the death certificate as been signed by the attending physic should be detached for use as the 2.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal do 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	□Ectopic pregnanc □ Other (specify) _	у		2	23d. Date of deliving Month	•	Year
0_	uires that the de n signed by the a lid be detached t	by	Part II. Other significant conditions con	tributing to death but not resulti	ng in the I	underlying cause gr	ven in Part I.		tobacco u Yes 2[se contribute to		death? Unknown
Records,	The law requir ate has been si page 2 should l	Completed						24a. Was auto perfe	psy ormed?	death?	topsy findings ompletion of c	available ause of
of Vital	Physician: The I this certificate ha	Be	25. Was case referred to medical examiner?					ath (Check only	опе)			
<u></u>	Physician: r this certificanal director.	2	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 EF		nt 3 DOA		lome 5 ☐ Resi			efy)	
ion o	fter fter	atlon:	27. Manner of Death 1 Alatural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury 2: (Month, Day Year)	8b. Time o Injury	Wo	ryat irk?]Yes 2 □No	28d. Describe				
Division	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely tilled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, s	reet, factory, office		28f. Location (City or To		d Number or Ru)	rai Route Nun	iber,
	e Hospit 124 hour 18 Funera 18tely till	Medical	29a. Certifier 1 Certifying Physical (Check only one) 1 Medical Examination (Check only one)	sician: To the best of my knowle ner: On the basis of examinatio and manner stated.	edge, dea n and/or i	th occurred at the to exercise the top occurred at the top occurre	me, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	s)
	withir To th	ž	29b. Signature and title of certifier			29c, Licen	se number		29d. Dat	e signed (Month	n, Day, Year)	
			1/1/1			1	55958		3/	24/0	0	
			30. Name a d address of person who co	m leted se of death (Item 2	3a) (Type	, Print)	4 SW	00.	1	e . No.	1210	61
			31. Date tiled (Month, Day, (Year)	20//Registrar's Signatur	C.W	HIGHWA	4 500	OCCN Z	2017	6 140	010	
	St: Regist	ate [®] rar	MAR 2 8 20	06 A Server 10	A.		J					

		1	For State Registrar	State of Maryland / Dep Ce	artment of Health and ertificate of Death		ene () ()	11708
	Physicia		1. Decedent's Name (First, Middle, Las			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al		REMAN	4b. City, Town, or Location of Deat	APRIL	4 2006 4c. County of Death	2:17p M
	Examin	er	4a. Facility Name (If not institution, give			,m	4c. County of Death	
	Funeral		4812 E. Hoffma 5. Social Security Number 6. S		Baltimore If Under 1 Year If Under 24 Hrs		9. Birth	place (State or Foreign intry)
	Director		233-38-5438	□ M 2 F 80 Yrs.	Months Days Hours Min.	May 8		t Virginia
	p .	l ⊢	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or L	ocation			10d. Inside City Limits
	show		MD	Baltim				1 Yes 2 □ No
	the N	ect	10e. Street and Number	Baltim	10f. Zip Code	109	g. Citizen of What Cou	intry?
	3e or	Ö	4812 E. Hoffma	n St.	21205	,	J.S.A.	
	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show ta Mudgel Evaruiner mual be notitied at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Amer Black, White	
ထ္ထ	or ite	F	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:			White
8	hours urel',	d by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	edent's Usual Occupation	10	6b. Kind of Business/li	ndustry
7	in 72	Completed	(Specify only highest gra	ade completed) (Giv	e kind of work done during most of wo DO NOT use retired)	orking		•
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) Pac	king Inspector	S	oap Manu	facturer
Maryland 21215-0036	e filed al Hygie l other vent, L	Be C	17. Father's Name (First, Middle, Last,)		me (First, Middle, Ma		
<u>ylaı</u>	2 should be f and Mental H is marked of reumatic eve	10	Mirl Drake			Pearl Mo		in Cordol
Jar	2 short and rism		19a. Informant's Name/Relationship (Type, Print) 19b. Mai lahan (daughter)	ling Address (Street and Number or R 8206 Wilson			
	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "neturel; or items 23e or 28e-1 show or other freumatic event, the Medical Examinat must be notified at	1	20a. Method of Disposition	20b. Place of Disp	position (Name of		0c. Location - City or T	
nor	ages ont of it: if it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special	Hemoval from State Maccox	ematory or other place) Cemetery 4/7	/06 M	Massey, M	ID.
altimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot	1	21. Signatura of Funeral Service Lice		22 Name and Address of Facility	II	C.L 1	T Calanak
ä	Depa Impo eny it	11	1/1/	M00510 1	alena Funeral 18 West Cross	St. Gale	na, MD.	21635
	4.		23a. Rant1 Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not e	nter the mode of dying, such as cardia	ac or respiratory arres	st,	Approximate Interval Between Onset and Death
1	Pnysician	i n	Immediate Cause (Final disease or condition	a. Small Cell Lu	ng Cancer			
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Metatasis to Due to (or as a consequence of):	Brain			11 mons.
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Hypertension				years
ó	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequence of):				_
8760,	ate hys	dical		d Coronary Arte	ry Disease			years
9	death certific e attending p id for use as l	/Mec	IF FEMALE:	23c. If yes, outcome of pregnancy	A CONTRACTOR		23d. Date of deli	verv
Вох	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	B Ectopic pregnancy Country Other (specify)		Month	Day Year
o.	the d y the	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown				
٠ <u>,</u>	The law requires that ite has been signed b bage 2 should be deta	by P	-	contributing to death but not resulting in the			acco use contribute to	
ords	w require been sig should b	led l	Seisures, Hyp	<u>erlipidemia, His</u>	tory of Breast	1 \ Yes	s 2 XXNo 3 LIPro	obably 4 Unknown
Vital Records,	law re as be 2 sh	ompleted	Cancer, Gastr	oesophageal Refl	ux Disease	24a. Was an autopsy	prior to d	topsy findings available completion of cause of
E R		Son					XNo 1 Yes	2[X]No
Vita	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital:	Other	eath (Check only one		
of	Phys this ral di	1. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe ho	nce 6 ⊡Other (Spec w injury occurred	шу)
On	Attending I r death. ector: After by the funer	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Work? M 1 □ Yes 2 □ No			
Division	or Attendi after death. Director: A in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		street, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,
	pital or A burs after leral Dire	Cer						
	To the Hospital or A within 24 hours after To the Funeral Director To the Funeral Director Director Filled in by	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my knowledge, de iminer: On the basis of examination and/or	ath occurred at the time, date and plac investigation, in my opinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Med	29b. Signature and tittle of gertifier	and manner stated.	29c. License number	29	d. Date signed (Monti	h, Day, Year)
	8 7 % 7		1/000en	Keille MIL	D54749	A	pril 5,	2006
	1		30. Name and address of person who	completed cause of geath (Item 23a) (Typ				•
	9		Allen Reilly	, MD. 4 East Rol	ling Cross Rd.	Baltimo	re, MD.	21228
1	St	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	arti			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 4a 10e per dock fh g854 4-25-06 vt State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26ay 2008 Physician MARCH 6:50 Р м YOUNG HELEN LOUISE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S 2823 MUESERBUF GLENARDEN COURT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Statements) | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | Nort 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🔀 F Yrs. 58 230-68-5667 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rthan "natural", or Iteme 23a or 28e-f ehov the Medical Examinar must be rigitified at 1√ Yes 2 No MD PRINCE GEORGE'S GLENARDEN Direct 10e. Street and Number bush 10f. Zip Code 10g. Citizen of What Country? 20706 2823 · MUESERBUT ·COURT U.S.A. Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. ☐Yes 2 🗷 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ BLACK 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs PROCUREMENT SPECIALIST GOVERNMENT le marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RUTH L. BACKUS **EUGENE** SLAUGHTER SR. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 5710 16th AVENUE # 4 HYATTSVILLE, MARYLAND 20782 TRINETTE YOUNG/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of h Important: If Ite any Injury or of once. 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State LANDOVER, MARYLAND 4/1/2006 HARMONY CEMETERY 4 ☐ Donation _5 ☐ Other (Specify) 21. Signature of Fundal Service Licer 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ALVEOLAR RHABDOMYOMA SARCOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physiclen a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ۵ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown certificete has been sl rector, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 21X No 1 ☐ Yes 2€ No 1 TYAS Be 25. Was case referred to medical 26. Place of Death [Check only one] Other: 4 Nursing Home S Residence 6 Other (Specify) Hospital: ၉ 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Sign After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funerel Direct 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDWARD SAUSVILLE M.D. 22 SOUTH GREEN STREET SUITE S9D01 BALTIMORE, MARYLAND 21201 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

MAR 3 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 30 2:45 PM 06 Virgie Viola Youngblood 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Coffman Nursing Home 1304 Pennsylvania Ave. Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Davs Hours 1 □ M 2 X□ F Vrs 99 Dec 23 1906 214-09-7144 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County 1X Yes 2 No Maryland Washington Hagerstown 10e.Street and Number Coffman Nursing Home 1304 Pennsylvania Ave. 10f. Zip Code 10g. Citizen of What Country? 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Personal Residence Homemaker 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Catherine Cline Rodgers John Calvin Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1391 Jefferson Blvd. Hagerstown Maryland 21742 Janet L. Mason (great niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4-3-2006 Hagerstown Maryland Rose Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Murlas Approximate Interval Between Onset and Death 23a. Part 1. Enter the 1.5 ase, or commiscations that caus + the death. Do not shock, or heart rail re. List only one cause on ear 1 to e. anter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due t Caremorna of Scal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 | Yes 2 | € No 24a. Was an autopsy perform 24b. Were autopsy findings available in r to completion of cause of eath? 1 Yes 2 No 1 ☐ Yes 2 Z-N0 25. Was case referred to medical 26. Place of Deal theck only one examiner' Other: 4 2 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner 🔟 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

/Medical Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed Attending Physician: Division death. with n 24 hours after or To the Funeral Direct completely filled in by ŏ

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Director:

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Physician

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Pages 1 and 2 should be fill iment of Health and Mental H lant: If item 27 is marked other

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Physician

filed within 72 hours after death

Baltimore, Maryland 21215-0036

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Certification:

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3 Suicide

29a. Certifier

4 | Homicide

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State Registrar 31. Date filed (Month, Day, Year) MAR 31

29b. Signature and title of certifier

2006

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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Allen.	Tashena

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

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03	Physician/ Medical Examiner
7416	Funeral Director

Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any
injury or other traumatic event, the Medical Examiner must be notified at once. Physician /Medical examiner

Division of Vital Records, P.O. Box 68760, To the Itospiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

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		1 - For State of Maryland Registrar		artment of H rtificate of		and Mental Hy	/giene Reg. No:-	6 1712
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Charles Alston Jr.				2. Date of D Month April	12 ^{Day} 2006	
Examin	er	4a. Facility Name (If not institution, give street and number) 3501 Milford Ave 5. Social Security Number 6. Sex 7. Age (In yrs. las	A lin implementary of	4b. City, Town, o Baltin If Under 1 Year			4c. County o	N/A
Funeral Director		5. Social Security Number $240-48-7631$ 6. Sex 1 2 1 2 1 2 1 2 1 2 1 2 1 2 2 2 2 2 2 3 4 2 2 2 2 2 3 4 2 2 2 2 3 4 2 2 2 2 2 3 4 2 $^{$	Yrs.	Months Days	Hours	Min. Jan	4,1935	9. Birthplace (State or Foreign Country) S. Carolina
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th with the 23e or 28 ist be no	Funeral Director	10e. Street and Number 3501 Milford Ave		10f. Zip Code	2120	7	10g. Citizen of Wi	us Country?
hin 72 hours after death with the Marylan e. en "naturel", or Items 23e or 28e-f show Madical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Marned It Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2∯ No	lispanic Orig an, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	Black	- American Indian, , White, etc. Black
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tould be fit Mental H narked ot natic svsr	To Be	17. Father's Name (First, Middle, Last) Charles Alston Sr.	401 14 111		Mar			
permit. Pages 1 end 2 should be filed withir Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then eny Injury or other traumatic event, Ins. Magnee.		James A. Hill / Provider	3501	Milfor	d Av	e Baltimo Date .4/19/06	ore MD 2	
permit. Par Depertmen Important: sny Injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facilit	Chatman	-Harris	Funeral Hom
Physician /Medical Examiner whision and per purial-itansit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause). The consequence of the cause in the caus	nce of):	y tevilu	n			Onset and Death 9 years
death certifica ie ettending pl ad for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetat de 4 □ Pregnant at time of deal	eath 3	Ectopic pregnanc	′		23d. Date Mont	of delivery h Day Year
The law requires thet the de. ste has been signed by the e bage 2 should be detached f	ξ	Part II. Other significant conditions contributing to death but not resulting _	nderlying cause gr	en in Part I.]Yes 2□No 3	oute to the cause of death? B Probably 4 Minknown	
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To To cor		29b. Signature and title of certifier Bangan (20cc) MD		29c. Licens	212		u /14/	(Month, Day, Year)
Sta Registr		30. Name and address of person who completed cause of death (Item 2 BON YON 6 P. THANA M.). 5 31. Date filed (Month, Par. Year) 4 2006 32 Tegistrar's Signature.	3a) (Type,	RESTO	KSTI	CWN RD	BALTIMO	RE,MD2WIS

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			Registrar		Ce	rtificate of D	eath		eg. No. UUt)	11/13
	Physici	an	Decedent's Name (First, Middle, La	,				2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic		DOROTHY JANE						10,2006	2:45 A M
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or t		n	4c. County of Deat	
			Manor Car 5. Social Security Number 6. S		n yrs. last birthday)	Rossv If Under 1 Year	IIILE If Under 24 Hrs.	9 Date of Birth	Balti	
	Funeral Director			. M 2 XF 7. Age (//	89 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 2	Year) Co	nplace (State or Foreign untry) ryland
			Usual Residence of Decedent			l		DCC. 2	, TOTO MA	ryrand
vlan	how		10a. State 10b. County		Dc. City, Town or Lo	ocation				10d. Inside City Limits
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athw	23a	rai	8100 Rossville			212			USA	
ar da	E H	une	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
S aft	2 1	by F	1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes XXXNo	Specify:		Specify: Wh	ite
	E H	edi	15. Decedent's E		16a, Dece	dent's Usual Occupat	ion		16b. Kind of Business/	odustry
-C Z : -C zz nithiw	- 7	plet	(Specify only highest gra	ade completed)	(Give	kind of work done du DO NOT use retired)	iring most of wor	rking		
	r the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema	ker		At Hom	е
	al Hygi other vent, I	BeC	17. Father's Name (First, Middle, Last,				18. Mother's Nar	ne (First, Middle, M	Maiden Sumame)	
	8 2 <u>0</u>	일	Arthur J.	Weber			Edna C	lazey		
Maryland	a = 2		19a. Informant's Name/Relationship (•		-			City or Town, State, 2	. ,
	Heelth sm 27 sther tr		Nancy Lee Buettner				ive-Balt		ryland 212	
Pages 1	or of H		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, creations FVans Filiner	nation (Name of malory or other place) The pel Berein (Name of the pel Berein)			20c. Location - City or	
			4 □ Donation 5 □ Other (Specif	,,		Ai-	r ı			11, Maryland
Baitimore,	Departr Imports any inj		21. Signature of Funeral Service Licer	nsee Y	22	2. Name and Address	of Facility EVAY	S CHAPEL, C	F MEMORIES ville,Mar	_ 21234
	102 e u		220 Rod Fotos the disease of som	11= tadole						
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each hae.	death. Do noveni	er the mode of dying,	, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
	hysician Medical		Immediate Cause (Final disease or condition resulting in death)	a	men 7	a				lycai
	xaminer			Due to (of as a co	onsequence of):					1
		r.	Sequentially list conditions,	b. Due to (or as a co	onsequence of):					
pet	Insit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury							
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OX 68	ettending phy I for use as the	Medi							I	
DOX	endir r use	an/k	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		Ectopic pregnancy			23d. Date of deli	•
. 0	0 2	sicia	in the past 12 months? 1 Yes 2-10	4☐Pregnant at tim 9☐ Unknown		Other (specify)			Month	Day Year
r i	ed by the detached	Physician/Med	9 🗆 Unknown						4	
Ords, P.O	5.0	þ	Part II. Other significant conditions of	contributing to death but n	ot resulting in the u	nderlying cause giver	n in Part I.		pacco use contribute to	
	been si should b	Completed						1 □ Ye	es 2. No 3 Pro	obably 4 Unknown
I Mecords The law requires		nple						24a. Was a autops	y prior to c	topsy findings available ompletion of cause of
		Š	2000					perform	ned? death?	2□ No
Vital	nis certificete I director, pag	Be	25. Was case referred medical examiner?	Hospital:				th Check only on	8)	
y.	this raldir	<u>1</u>	1 Yes No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier		4 Nursing H		nce 6 Other (Spec	ufy)
ם פֿוֹ	After funer	ē	1 Natural 5 Pending	(Month, Day Ye	ear) Injury	Work?	at es 2 □No	280. Describe no	w injury occurred	
DIVISION Of VITA	deat ctor: y the	fica	3 Suicide 6 Could not b	e 200 Place of Injury	- At home, farm, str	11.5	03 2 1110	28f. Location (St.	reet and Number or Ru	ral Route Number
= 6		Certification:	4 Homicide determined	building, etc. (5	Specify)	cot, factory, office		City or Town	, State)	arribalo Wanbol,
Hospital	within 24 hours effector the Funeral Director Completely filled in		29a. Certifier 1 Certifying Pt	nysician: To the best of m	ny knowledge, deat	h occurred at the time	, date and place	, and due to the ca	luse(s) and manner as	stated.
Į.	hin 24 h the Fu npletely	edicai	(Check only 2 Medical Examone)	miner: On the basis of ex-	amınation and/or in	vestigation, in my opi	nion, death occu	irred at the time, da	ate and place, and due	to the cause(s)
Tothe	within To the comple	M	29b. Signature and title of certifier			29c. License	number	25	9d. Date signed (Manti	Dey, Year)
)			· YW	M11.		1)4	4793		4/14/0	6
10	9		30. Name and address person who	completed cause of death	h (Item 23a) (Type,	Print)k / /	1	At Inn	7 11 -	
4	V		H. Jaha,	6+30	Holah	ud M	Das	x MI	2/222	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pegistrar's	Signature	nelle				

Physician /Medica Examiner Funeral Director	n	1. Decedent's Name (First, Middle, Last)					Death	10	Date of		No.)	3. Time of Death	
Funeral	_	Kenneth Woolf 4a. Facility Name (If not institution, give str	ord Ander	rs, Sr.		City, Town, or	Location of D	Α			2006 4c. County of	/ear Death	10:30 P	
		Gilchrist				4b. City, Town, or Location of Death TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth					Baltimore			
		210 14 7017	7. Age (i	In yrs. last birt		Inder 1 Year oths Days		din. S	ept,	18', Y	°¶923	Mar	place (State or Fore Mand	
death with the Maryland ms 23a or 28a-f ahow rmsst La ricilited at maryl Director		Usual Residence of Decedent 10a. State 10b. County Md. Baltimore	1							10d. Inside City Lim 1 ☐ Yes 2X				
3a or 28	Dire	10e. Street and Number 4212 Kensington Rd.				10f. Zip Code 21229					Citizen of What Country? USA			
J35 urs after iii, or ite	by Fur	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Ev. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:				of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.) No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
d within 72 hours aff giene. et than "natural", or it a Medical Exami	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) +4 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) CPA						working	16b. Kind of Business/Industry Accounting					
land land land land land land land land	To Be C	Jessie Lincoln Anders						s Name (First, Middle, Maiden Sumame) ude Woolford						
Mary nd 2 shou lith and M 27 is mar r traumat	_	19a. Informant's Name/Relationship (Type, Print) Mr. Kenneth W. Anders, Jr./ Son 816 Kellogg Rd. Lutherville, Md. 21093										p Code)		
Baltimore, Maryland semil. Pages 1 and 2 should be file Department of Health and Mental Hy mportant: if item 27 is marked oth iny injury or other traumatic event pages.		20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	20b. Place of cemeter	Disposition by, cremator op Ser	(Name of y or other plac 'Vice C	o. 4-	Dat 12 -		20	Towsor			
Departition Department on the property on the property in the property on the property on the property on the property on the property on the property on the property on the property on the property of the		21. Signature of Feneral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath												
760, 16 be executed ysicien and burial-transit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) a. Congestite Iteart failure Due to (or as a consequence of): Is Chemic Cardiomyona Py Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
Vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifica r death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							_	23d. Date of delivery Month Day Year			
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on of Vital Figure 2 ving Physician: The Atter this certificate funeral director, page	To Be	25. Was case referred to medical examiner?									r (Spec	ity) ltospie		
Sion of eath. or: After thi	Certification:	27. Manner of Death 1 Actident 2 Accident investigation 3 Suicide 6 Could not be		Work? M 1 Yes 2 No						-/				
Dir rs afte al Dir ed in	Certifi	286. Place of Injury - At home, farm, street, factory, office determined 287. Location (Street and Number of Hural City or Town, State) 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 289. Certifier 280. Certifier 280. Certifier 280. Certifier 281. Location (Street and Number of Hural City or Town, State)												
the Hosp hin 24 hou the Fune mpletely fi	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.				nvestigation, in my opinion, death occurred at the tim				me, dat	ne, date and place, and due to the cause(s)			
To the Within To the comment	Σ	29b. Signature and title of certifier									April, 9, 2006			
5+1		30. Name and address of person who con Sason Rac K 6 31. Date filed (Month, Day, Year) APR 1 4 20	(Type, Prin											

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State of Maryland / Department of Health and Mental Hygiene Dean Alan Brewer Registrer Amend Item #10c&f Per FIC 855 at 1206 h JH 2. Date of Death 3 Time of Death Physician/ April 12, 2006 1050 hrs Medical Examiner Dean Alan Brewer Allan Brewer Dean 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Kingsville 8134 Bradshaw Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Foreign Months Days Hours Director Country) 213-60-0979 06/08/1962 MD 1 X M 2 F 43 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Kingsville Baltimore Bradshaw or 28a-f show Maryland death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21087 21021 U.S.A. 8134 Bradshaw Road 23a Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 Married Yes White Specify: 1 Yes 2 X No specify: 4 X Divorced If Yes. Give Year es 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene If item 27 is marked other than "natural", ther traumatic event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) eted Self-Employed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Transmission Shop Owner 12 Com 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donald Margaret G. Deibel Be Brewer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic 9602 Northwind Road, Baltimore, ND 21234 Mrs. Donna Palmer (sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State tment o 4/14/2006 Baltimore, Maryland Bayview Crematory Donation 5 Other Specify. 22. Name and Address of Facility Schollune uner omes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a Contact Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X AMENDED UNPENDED item#1,perME,g855,5/10/06 TT Box 68760 use as the but 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes 2 No page ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA ۵ 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury FOUND: Day, Year) 28c. Injury at Work' 28b. Time of Injury After 27. Manner of Death Certification: Subject shot self **FOUND** Natural 1 Yes 2 ✔ No 5 Pending death. Apr 12, 2006 To the Funeral Director: 1047 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide 6 Could not be or Town, State) 8134 Bradshaw Road, Kingsville, MD determined (Specify) Single Family 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E April 13, 2006 w o completed cause of death (Item 23a) 30 Name and address of person 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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rtley, Garry		State Registrar	te of Maryland		artment of rtificate of		and I	Mental I	łygiene	Reg. No.	200	6	11718
Physician	_	Decedent's Name (First, Middle, I	Last)						2. Date of D Month		Year	3	Time of Death
edical Examin		GARRY DUAM							April 10	2006			8:26
	ı	 Facility Name (if not institution, 904 Park Avenue Aparn)	4	b. City, Tow Laurel	n, or Loc	ation of Dea	th		County of De		
Funeral Director	٦		. Sex 7. Ac	ge (In yrs. I	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24H Hours M	in:	23,		Count	lace (State or Foreign ry) ryland
		Usual Residence of Decedent											_
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2121 buld be fi I Mental I marked ie event,		19a. Informant's Name/Relationship	_		19b. Mailing	Address (r Rural Route N		_	tate, Zi	p Code)
e, MD I and 2 sho Health and item 27 is		Jessica Karin Mi 20a. Method of Disposition		20b.	Place of Disposi	tion (Name			Boulder,		orado ocation - City		304 wn, State
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumant		1 Burial 2 XX remation 4 Donation 5 Other Spec 21. Signature of Funeral Service Li	cify:	1010	est Arun 22. N	del C: ame and Ad onald:	dress of SON	_{Facility} Funera	1/12/200 1 Home, 1ue Lai	P.A			
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O,	Š	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco		2 Fet	al death ner (Specify		Ectopic preg	nancy		. Date of deli Month	very Day	Year
the de cy the ched f	Phy	Part II. Other significant condition		th but not r	resulting in the u	nderlying ca	ause give	n in Part I.	23e Die	d tobacco u	ise contribute	e to the	cause of death?
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Vita hysicia this ce I direc	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	ient 2	ER/Outpatient	3 DOA	A Oth	ner 4 Nurs	sing Home 5	Resider	nce 6 🗸 C	ther S	cene
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Division To the Hospital or Attendi within 24 hours after death To the Funeral Director: v	Certification:	3 Suicide 6 Could determ	not be 28e. Place of I		nome, farm, stree	t, factory, of	fice build	ding, etc.	or Town	, State)			Route Number, City J. Laurel, MD
8 4 = -	Medical C	(or con only	rsician: To the best of r	amination a	-								
To Wi	Me	29b. Signature and title of certifier	and manner stated			29c. L	icense n	umber		29d. E	ate signed	(Month	, Day, Year)
		anals	2	MD		(D.C.M.	E.		Apri	11, 2006	5	
12+1		30. Name and address of person w Ana Rubio MD. Assis	tho completed cause of stant Medical Exa		^{n 23a)} 111 Penn S	treet, Ba	ltimore	, MD 212	01				
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DHMH 17 Rev 1/2001 OCME 10/2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 11ten 9 per 1h 8854 4-14-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 245 am 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Universit ot Maryland Huspital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Westning I ginia **Funeral** 219.32.856 1 M 2 ☐ F Davs Year Months Hours Min. Director William A Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. t ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be f nent of Health and Mental H ant: If item 27 is marked of Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State HANOVER Baltimore, 20a. Method of Disposition Date Department of I 1 Burial 2 Cremation 3 Removal from State ត inlury 4 ☐ Donation 5 ☐ Other (Specify) RIDGE CEM- 41-15-06 21. Signature of Tope al Service Licensee 22. Name and Address of Facility eny ic Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part 1. Enter the disease, or complications mat shock, or heart failure. List only one cause on eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Cardioa enic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Box 68760~ physicien are s the burial-t Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Year Dav 5 Other (specify) P.0. detached 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, pe 1 Tes 2 1 No 3 ☐ Probably 4 ☐Unknown funeral director, page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 2 No 1 ☐ Yes 2 No Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 Dinpatient 2 ER/Outpatient 3□ DOA o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter Division 1 Natural 5 Pending death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Freenestrat, Ballmore MD 2(201 Cittrynh 22 31. Date filed (Month, Day, Year) Rebistrar's Signature State Registrar 4

		1 - For State Registrar	State of Mai	yland / Dep		Health and	Mental Hyg	iene 006	11720
		1. Decedent's Name (First, Middle, Las	")				2. Date of Deat		3. Time of Death
Physici		James	Elbert	F	Satton		April 12	2, 2006 Year	6:55a M
/Medio Examir		4a. Facility Name (If not institution, give			-	or Location of Deal		4c. County of Dea	
CXMIIII	iei	7352 Point Patien	co Way		Elkrid			Howard	
Funeral		5. Social Security Number 6. Se		(In yrs. last birthday) If Under 1 Year	If Under 24 Hrs	8. Date of Birth		thplace (State or Foreign
Director		220-46-9090	RM 2□F 56	Yrs.	Months Days	Hours Min			ryland
D		Usual Residence of Decedent					12100 1 2 2	, 12 12 1	
rylan how		10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits
a Ma	Ş	Maryland Howard		Elkridg	ge				1 ☐ Yes 2 ☑ No
portition of the proof of the control of the contro	al Director	10e. Street and Number 7352 Point Patien	ce Way		10f. Zip Code 2107	5	1	0g. Citizen of What Co USA	ountry?
deat	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S. 13	. Was Decedent of If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
after a	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				to Hican, etc.)	Black, Whit	
urs a	þ	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:		1□ Yes 2☐No	Specify:		Specify: Wh	ite
2 ho	Completed	15. Decedent's Ed	ication	16a. Dec	edent's Usual Occure kind of work done	pation	dina	16b. Kind of Business	Industry
Pin 7	pie	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retire	ed)	rking		
d will	Ö	12			oeditor			Westingh	ouse
vent Hy	Be	17. Father's Name (First, Middle, Last)		-	•	18. Mother's Na	me (First, Middle, M	Maiden Surname)	
Aents Aents tice	To	William	Batt	on		Anna		Moeller	
shot shot will be made	-	19a. Informant's Name/Relationship (T	vpe, Print)	19b. Mai	ling Address (Stree	t and Number or R	ural Route Number,	City or Town, State,	Zip Code)
Malth a 27 is a rtra		Susan D. Kessler	(Sister)	3122	2 Birch B	rook Ln.,	Abingdo	n, MD 2100	9
S 1 a f Hag item other		20a. Method of Disposition		20b. Place of Disp	oosition (Name of ematory or other pla	acal I	Date :	20c. Location - City or	Town, State
Definition Pagas Separtment of Exportant: If it in your or on injury or one ince.		1 Burial 2 □ Cremation 3 □ I '4 □ Donation 5 □ Other (Specify)		New Catl	nedral Ce	metery 4/	/17/06	Baltimore,	Maryland
nit. Finartmontar		21. Signature of Funeral Service Licens		163	22. Name and Addre	ess of Facility T.c	udon Par	k Funeral	Home
D Series D S		1						more, MD 2	
		23a. Publication the disease, or comp	lications that caused th	ne death. Do not e		TT 17.			Approximate
Physician IMedical Examiner portion and point in provided in the provided in t	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, i. a.y, e.g. or injury that initiated events resulting in death)	Due to (or as a of the control of th		enosi of the	s liver l disea	rse		Interval Between Onset and Death
re be ex ysician a e burial			Due to (or as a t	consequence-or):					
ate b hysic the b	lical		d						
o certific anding p	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		Π 5			23d. Date of del	ivery
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Attent this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at tir 9☐ Unknown		□Ectopic pregnand □ Other (specify) _	-9		Month	Day Year
s that	by PI	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
d be							1 ☐ Ye	s 2.0 No 3 □ Pr	obably 4 Unknown
w requ	ompieted						24a. Was ar	24h Were a	topsy findings available
ne lav has ge 2	E D						autops	y prior to	completion of cause of
n: The	ပ						1 ☐ Yes 2	P. To 1 ☐ Yes	2 🗆 No
vician: T certificat rector, p	Be	25. Was case referred to medical examiner?	Hospital:		Ot	han	ath (Check only one		
Phys this	٦.	1 ☐ Yes 2 ☑ No ☐ ☐ 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	SIL SLIDOA	4 Nuising r	lome 5 Reside 28d. Describe ho	ince 6 Other (Spe	ofy)
tending leath. tor: After the funa	io	1 Anatural 5 Pending	(Month, Day)	/ear) Injury	Wo	ork?]Yes 2∐No	200. 2000/100 110	w many occurred	
ttend death death ttor:	ertification;	2 Accident investigation 3 Suicide 6 Could not be	200 Place of leium	. At home form			28f Location (St	reet and Number or Ru	eral Pauta Mumbar
or A or A or A or A or A or A or A or A	ĮĮ.	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	treet, factory, office		City or Town		rai nodie Namber,
To the Hospital or Attending Physician: The law within 24 buotrs after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	O	29a. Certifier 1/V Certifying Phy	elelen Z-w- t- t-	mules of the later of the	th and the second		(i)		
Hosi 4 ho Fune tely f	edicai	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of e	xamination and/or i	ith occurred at the ti nvestigation, in my	opinion, death occu	e, and due to the ca urred at the time, da	iuse(s) and manner as ite and place, and due	to the cause(s)
the the	Med	29b. Signature and title of certifier	and manner state		29c Licen	se number	20	9d. Date signed (Monto	Day Vess
Twit To So			Attendin	a Phucia	ikm D	62100	28	4/12/7	10/
				7 1 37516	To the	0 1100		111012	000
10		30. Name and address of person who o		th (Item 23a) (Type	Print)	Ito spit	ul 900 4	S. Caton.	Ave.
,		100	uppusan	3 / 1	4	0	- / (
Sta Registr		31. Date filed (Month, Day, Year) APR 1 4 200	32 Registrar	s signature	and			ed. Date signed (Monti 4/13/2 5, Catm	

			1 _ State	State of Maryland	/ Depa		lealth and M	ental Hygie	enen n 6	1 7	21
			Registrar			rimeate or i	Deatri	2. Date of Death	J. No.	3. Time of	Death
	Physici	an	1. Decedent's Name (First, Middle, Last)				-	Month .	Day Yeer	6:10	PM
	/Medic		Ethel	Jane Bie	en I	41. Ch. T.	1	Heri	4c. County of Death		
	Examin	er	4a. Facility Name (If not institution, give st	reet and number)			r Location of Death				
			Levindale	7 4 // /	a fortunda edo e el	Baltim If Under 1 Year	IOTE If Under 24 Hrs.	9 Date of Birth	N/A	alana (Stata a	r Forning
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	τ οιππααγ) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State o	r r-oreign
	Director		216-28-0837 Usual Residence of Decedent	M 2 A F 75				April 30.	,1930 Mai	<u>ryland</u>	
	and and		10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside Ci	ty Limits
	f sho	ō	Maryland N/A	Ral	timo	ro				1 □XYes	2 🗆 No
	ith the Marylar or 28e-f show	ect	10e. Street and Number	Βαι	CTIIIO	10f. Zip Code		100	g. Citizen of What Cou	intry?	
	with o	۵				2123	0		-7 -1		
	eath	era	1411 Limit Avenue	2. Was Decedent Ever in U.S.	13.			ecify Yes or No-	U.S./		
	ter d	un.	1 ☐ Never Married 2 💢 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	ĺ		lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	, etc.	
336	urs al	by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	ni te	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or ltems 23e or 28e-f show he Medical Exandine must be modified at	Completed	15. Decedent's Educ		16a. Dece	dent's Usual Occup	pation	16	6b. Kind of Business/I		
75	nin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most of worki d)	ng			
21	d will	mo;	8		0f	fice Man	ager		Insurance	9	
	should be filed with nd Mental Hygiene. s marked other the umatic event, he	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	aiden Sumame)		
<u>a</u>	Menta Menta rked tice	To	John Landis				Edna	Momberge	er		
Maryland	2 should be filed within and Mental Hygiene. is marked other then eumatic event. The M		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number, (City or Town, State, Z	p Code)	
	1 and 2 Health a em 27 is ther tre		William Biehl	Husband	141	l Limit A			Maryland	21239	
Baltimore,			20a. Method of Disposition	20b. Plac	ce of Disponentery, cre	osition (Name of matory or other place	ce)	Date 20	Oc. Location - City or 1	own, State	
Ë	permit. Pages Department of Importent: If it eny injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval nom State			orp. 4-12	-2006 T	Towson N	1arylan	ıd
Ħ	permit. Pa Departmer Importent eny injury once.	1	21. Si naure i Funs al 3 rice License			2. Name and Addre	an of Facility		n Funeral		
m	Depar Impor eny ir		town attacan			1050 York	Road To	owson. Ma	aryland 212	204	THC.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death.						Approximat Interval Bet	e
			Immediate Cause (Final	A cause on each line.						Onset and	Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a conseque	_	2,20					-
П	Examiner			200 10 (01 00 2 00.100420							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Lijury that initiated events	Due to (or as a conseque	nce of):						-
1	uted ansit	뒽	cause. Enter Underlying Cause (Classes of Light)								
Ć,	exec n and ial-tra	Exa	resulting in death) Last	Due to (or as a conseque	nce of):						
760,	eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	d.								
68	ificat g phy as th										
Вох	nding use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23	ic. If yes, outcome of pregnand		Terrain avenue a			23d. Date of deli	very	
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal d 4 Pregnant at time of dea		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> _	у		Month	Day '	Year
0	oy the	hys	9 Unknown	9☐ Unknown							
٦.	wrequires that the death certifica been signed by the attending ph should be detached for use as th		Part II. Other significant conditions con	_	-		ven in Part I.	23e. Did toba	cco use contribute to	the cause of c	leath?
rds	quire in sig uld b	pe pe	Chronic Clost	RUCTIVE YO	lmo	rang VI	SEASE	1 Nes	: 2 □ No 3 □ Pro	bably 4 🗀	Jnknown
Records,		olete				/		24a. Was an	24b. Were au	opsy findings	available
Re	sicien: The law certificate has birector, page 2 s	Completed by						autopsy perform 1 ☐ Yes 2/	ed? death?	ompletion of c	ause or
Vital	ifficat	Ö	25. Was case referred to medical				26 Place of Death	Check only one		200	
S	Physicien: r this certifica ral director, I	To B	avaminar?	ospital: 1 Inpatient 2 E	R/Outnatie	nt 3□ DOA Oth	205	ALCOHOL: STATE OF THE PARTY OF	rce 6 ☐Other (Spec	ifu)	-
of	Phy r this eral d		27 Manner of Death	28a. Date of Injury 2	8b. Time o	12		28d. Describe how		,,	
on	eath. or: After th	tlor	1 Natural 5 Pending Investigation	(Month, Day Year)	Injury		rk?]Yes 2 □No				
Division	Attending r death. ector: After y the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	e, farm, st	reet, factory, office			et and Number or Ru	ral Route Nurr	nber,
οįς	after after Dire	erti	4 Homicide	building, etc. (Specify)				City or Town,	State)		
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification;		ician: To the best of my knowl							
	24 h 24 h 9 Fui	dic	(Check only 2 Medical Examinone)	er: On the basis of examination and manner stated.	n and/or ir	nvestigation, in my o	opinion, death occur	red at the time, dat	e and place, and due	to the cause(s	;)
	roth vithin ompl	Me	29b. Signature and title of certifier			29c. Licens	se number		d. Date signed (Month		
	->-0		A Cole M			DZ	3767		April 10	2,200	6
	- 0		30. Name and address of person who con	moleted cause of death (Item 2	23a) (Type				*, *, *, *		
	20		Debra Wertheimer,				venue Ra	ltimore.	Marvland	21215	
	St	ate	31. Date filed (Month, Day, Year)				TOTION DO				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Regist		APR 1 4 20	32. Angistrar's Signatu	5 1	POBALL					

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
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			State of Maryland / Department 1 - State Registrer State Of Maryland / Department Certificate				ene	6	11722
			Decedent's Name (First, Middle, Last)			2. Date of Death	1		3. Time of Death
	Physicia		Terry Lee Bruce			April 1	Day 1, 2006	Year	4:41 P M
- 1	/Medic Examin			Town, or	Location of Death	DETT. T	4c. County		4:41 P
	LAdilliii		GBMC @ Gilchrist Tows	on			Ral+	imor	~
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	1 Year	It Under 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreign
	Director		218-62-3986 1 M 2 TF 51 Yrs. Months	Days	Hours Min.	Mar. 7.	1955	Mary	vland
^ ,			Usual Residence of Decedent						
1	L bow		10a. State 10b. County 10c. City, Town or Location					1	0d. Inside City Limits
:		ţ	Maryland Baltimore Nottingham						1 ☐ Yes 2 XNo
į	27.28	Director	10e. Street and Number 10f. Zip 0	Code		10	g. Citizen of W	/hat Cour	ntry?
1	23a d	alC	4138 India Avenue 2	1236	5		USA		
4	illed within 72 flouts after beath with the Maryland Hygiene. Sther then "naturel", or Itema 23a or 28a-f show ent, the Madical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Forces? 13. Was Decedent Fyer in U.S. 15. Was Decedent Fyer in U.S. 16. Was Decedent Fyer in U.S. 17. Was Decedent Fyer in U.S. 18. Was Decedent Fyer in U.S. 18. Was Decedent Fyer in U.S. 19. Was Decedent Fyer	ent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		- Americ	can Indian,
9	or the		1 Never Married 2 Married 1 Yes 2 Married 1 Yes 2 Married 1 Yes 2		Specify:	7 110411, 0(0.)	Specify.		
3	en .	d by	3 ☐ Widowed 4X ☐ Divorced Year or Dates:	A	ороску.		Specily.	Wh	ite
ה ה ה	natu	Completed	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	k done a	luring most of work	ting 1	6b. Kind of Bu	siness/In	dustry
٠ ;	9 9	ld L	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use	e retired,)		eating		
4	t, the training	S	2 Customer s	Serv			ir Cond		ning
3	d off	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, M		•	
2	Men	၉	William (nmn) Hundertmark			<i>'</i> irginia	Sindal		
<u> </u>	permit. Fages I and 2 should be little within 72 flouts after beauth with the marynal bepertment of Heelih and Mentall Hygiene. Important: if item 27 is marked other then "naturel; or itema 23a or 28a-f show eny injury or other treumatic event, the Madical Examinar must be notified at once.	5	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (
2	and eelth n 27 rer tr	. ,	Sarah Bruce / Daughter 295 Parad						
ָ מ	of Titler roth		20a. Method of Disposition 1 ☐ Buriat 24☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name cemetery, crematory or oth	ie of her place	g)	Date 2	Oc. Location -	City or To	own, State
airino	rag nent ant: i		4 Donation 5 Other (Specify) Hilltop Service	e Co	orp. 4-1	4-06 To	owson,	Mary	land
<u> </u>	y in		21. Signature of Funeral Service Licensee 22. Name and McCompa	Addres	s of Facility ineral Ho	me D7			
۵	88 = 8		the a way is	okes	sbury Roa	d, Abing	don, Ma	ryla	nd 21009
	MOE.		23a. Part1. Enter the disease, or compilitations that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.	of dying	g, such as cardiac	or respiratory arre	st,	-	Approximate Interval Between
P	hysician	1	Immediate Cause (Final					- 1	Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):						moraly
E	Examiner		J						
		jer	Sequentially list conditions, I any, leading to inmediate Due to (or as a consequence of):			-			
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
·	exec n an ial-tr	Exa	resulting in death) Last Due to (or as a consequence of):						
00/0	cate be executed physicien and the burial-transit	dlcal	d.						
		(D)							
5	ndin use a	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date	e of delive	ery
	eate d for	cla	in the past 12 months? 1 Yes 2 10 10 2 The past 12 months? 1 Yes 2 10 10 2 The past 12 months?				Mor	nth	Day Year
j j	w requires that the death certifications been signed by the ettending should be deteched for use as	by Physician/M	9 Unknown						
r i	man ned b	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying car	use give	on in Part I.	23e. Did toba	acco use contr	ibute to th	ne cause of death?
8	sigr d be					}⊆ Ye	s 2 🗆 No	3 🗌 Prob	ably 4 Unknown
j i	w req	Completed				24a. Was an	24h V	Vere auto	ney findings available
E	has ge 2	Ę.				autopsy	ed? d	eath?	psy findings available impletion of cause of
	r pe					1 □ Yes 2	No 1	Yes	2 No
=	certii	Be	25. Was case referred to medical examiner? Hospital:	Othe		th Check only one			14.00
5 8	Physician: The law requires manne beam berin this certificete has been signed by the ettending rai director, pege 2 should be deteched for use a:	P	1 Inpatient 2 EPVOUtpatient 3 DOA	A laiun	4 □ Nursing H	ome 5 Resider			Mospice
	After Tuner	Certification:	and the state of t	Bc. Injury Work		28d. Describe not	w injury occurre	ea a	
Vision	death tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be		Yes 2 □ No	Oot I centice (Ct.			/8
<u> </u>	fter c	ŧ	4 Homicide 28e. Place of Injury - At home, farm, street, tactory, building, etc. (Specify)	office		28t. Location (Str. City or Town,		er or Hura	u Houte Number,
י ב	urs a								
:	To the hours after death, within 24 hours after death, within 24 hours after death, within 24 hours after death after this certificate has completely filled in by the funeral director, pege 2 completely filled in by the funeral director, pege 2.	Medical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in any one)	in my op	ie, date and place, pinion, death occui	and due to the car red at the time, da	use(s) and mai te and place, a	nner as s ind due to	tated. the cause(s)
:	the the	Mec	and mainly states.	License	number	ەر.	d. Date signed	/Month	Day Year)
	Z \$ 7 8			-		1	prul 11	2008	
	1			58	30	~			
3	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AALOA CHALUS, WO 660 N. Ch	. 1.	C+ 12.	trompe 4	m 2 6	ets.	
			N. I.	VV CE	7 21 175	M-MK .	0 210	7	
	Sta Registr								
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			For Stata Registrar	State	of Maryla	and / Dep <i>Ce</i>	artmer rtificat			nd Me		ene g.No.005	11723
	Physici /Medic		1. Decedent's Name (First, Midd Marie	C.	Corn	ell					Date of Death Month April	PY,2006	3. Time of Death 10:42a M
400	Examin		4a. Facility Name (If not institution Montgomery 5. Social Security Number	_	Hospi	tal	0	Town, or lney	Location of 0 7 If Under 24		Date of Righ	4c. County of Dea	omery
	Funeral Director		200-14-1499 Usual Residence of Decedent	1 M 2 1 F	89	Yrs.	Months	Days		Min.	Date of Birth (Month, Day, 8/02/1		rthplace (State or Foreign ountry) ttsburgh Pa
	the Maryland 28a-f show	Director	10a. State 10b. Count MD Mont of 10e. Street and Number	gomery	10c.	City, Town or L Olney		Codo			10	G Cibinan of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	eath with	Funerai Dir	18312 Queen		eth Dr			2083		n? (Specif		g. Citizen of What C USA 14. Race - Am	
-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "netural", or items 23e or 28e-f show event, I're Medical Examinar in ust be multified at	ed by Fun	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	rried 1 Tyes	Forces? S 2 X 3No Give		If Yes, spe	2₩ No	Specify:	Puerto Ric	y Yes or No- an, etc.)	Black, Whi Special hi	te, etc.
Maryland 21215-0036	filed within 72 Hygiene. other then "ne ent, tre Medic	Completed by	(Specify only higher Elementary/Secondary (0-12)	est grade completed College	d) (1-4or 5+)	(Give	NING of WO DO NOT U	nk done d	uring most o			Agricul	,
ryiand	should be fi ind Mental H is marked of umatic ever	To Be	17. Father's Name (First, Middle Anthony Humi 19a Informant's Name/Relation	mel		10b Mail	na Addros	/Street a	Clai	ra F	ranz	aiden Sumame)	Tio Code)
	1 and 2 Health a em 27 ls		19a. Informant's Name/Relation Wilma Anasta: 20a. Method of Disposition	ssopoulo		. Place of Dispe	osition (Na.	me of		izab Date		cive Oln Oc. Location - City of	
galtimore,	permit. Pages Department of Importent: If it any injury or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (3 21. Signatule of Fyneral Service	Specity)	n State	St.Mai	ry's	Cem	. 4/18			Pittsbur AL SERVI	
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease of shock, or hart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to	each line. ULT Co (or as a cons	9	241	Colu	mbia	Blv	d.Silv	ver Spri	Approximate Interval Between Onset and Death
X 68/60,	certificate be executed ding physician and ise es the burial-transit	/Medical Examiner	Sequentially list conditions, if a.y. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	o (or as a consi							224 Date 444	
CO. BOX	es that the death certific igned by the attending p be detached for use es	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live	birth 2 ☐ Fe gnant at time of	etal death 3	□Ectopic p □ Other (sp					23d. Date of de Month	Day Year
ecords, r	een s bluor	þ	Part II. Other significant condition	ions contributing to		esulting in the u			n in Part I.		_		o the cause of death?
итаі нес	The la ate has page 2	e Completed	25. Was case referred to medical	31	410				26 Diago of	f Dogth (C	24a. Was an autopsy performed 1 Yes 2 Scheck only one	od? prior to death? PNo 1 □ Yes	utopsy findings available completion of cause of
ō	ding Phy h. After this funeral d	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	Hospital: 28a. Date (Mo	Inpatient 2 e of Injury onth, Day Year)	ER/Outpatier 28b. Time o Injury	_	8c. Injury Work	r: 4 🗆 Nursi	ing Home 28d	5 ☐ Residen	ce 6 Other (Speringly occurred	ecify)
DIVISION	i Sirie	Certification:	4 Homicide	nined 286. Plat buil	ding, etc. (Spe						City or Town,		
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier Check only one Certifyi 2 Medical 29b. Signature and ritted certifie	Examiner: On the and ma	ne best of my k basis of exami nner stated.	nowledge, deat nation and/or in	vestigation	at the time, in my op	inion, death	place, and occurred	at the time, dat	e and place, and du	e to the cause(s)
	× 3 × 8		Sh	> PH	YSICIF	3N	6	31	68		290	1. Pate signed (Mon	Jay, 1801/
10) Sta	te	30. Name and address of person Shyam Parkie 31. Date filed (Month, Day, Year	MD		Princ		nili	p Dri	ve C	lney,	Md 2083	2
	Registr	_	APR 1 4	2006		H. Los	the						

06-02443	
Bussaura,	Julia

Bussaura, Julia		1- For State	tate o		d / Dep			elible ink nd Mental H	-	0	000	1 1 *7 0
Physiciar	_	Registrar 1. Decedent's Name (First, Midd	le,Last)	_		minouto o	, 200		2. Date of Deat		UUb;	3 Time of Death
Medical Examin	_	Julia Buss	ur	a Jul	ia Bous	ssari.			Month April 9, 20	Day \	rear	21:32
$\overline{}$	ı	4a. Facility Name (if not institution University Hospital	on, give	street and number	er)		4b. City, Town, or Baltimore	r Location of Death	1	4c. Coun	ty of Death	
Funeral Director		5. Social Security Number	6. Sex	7. A	Age (In yrs	last birthday)	If Under 1 Year Months Day				YY) 9 Birth Cour M.D	
		Usual Residence of Decedent										
w any	,	10a. State 10b. County			10c. City	y, Town or Locat	tion					10d. Inside City Limits
·land -f sho	ğ	MD			Ва	ltimor						1 X Yes 2 N
the Mary 3a or 28a	Director	7101 Ruther	for	d Greer	Cir	•	10f. Zip Code 21244			J.S.A.		ry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X XN	larried	12. Was Decede Armed Force				spanic Origin? (Sp n, Mexican, Puerto			ace - America hite, etc.	an Indian, Black,
after al", o	Ş.	3 Widowed 4 Dir	vorced	If Yes, Give Year or Dates:		1	Yes 2 X No	specify:		Specif	y Bla	ck
hours natur Exam	be	15. Decedent's Education (Spe			-	16a. Deceder during	nt's Usual Occupa	ation (Give kind of v	work done	16b. Kind of	Business/Ind	dustry
y, MD 21215-0036 and 2 should be filed within 72 hours after teath and Mental Hygiene tem 27 is marked other than "natural". traumatic event, the Medical Examiner	Completed	Elementary/Secondary (0-12)		College (1-4 o	or 5+)		working life. DO I	NOT use retired)		Hosp	pital	
15-C	ဒ	17. Father's Name (First, Middle						18. Mother's Name			me)	
AD 21215-003 2 should be filed within 1 and Mental Hygiene 2 T's marked other th matic event, the Medi	lo Be	James Taylon 19a. Informant's Name/Relations		ne Print \		19h Mailin	n Address (Stre	et and Number or I	s Dorse	-	own State 7	Zin Code)
MD 2 nd 2 shou alth and 1 m 27 is r		Frances Rob										MD 2124
e, N I and I Health item		20a. Method of Disposition				Place of Dispos	sition (Name of ce		Date		on - City or To	
nor ages ant of ut: If		1 XBurial 2 Crematio		Removal from		crematory or ot	Mem. Pa	ark 1_	17-06	Arbut	ue M	D
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr		4 Donation 5 Other S 21. Signature of uneral Service		ee //	9			s of Facility We				
Berr Perr Depriming		/////slas	//	har	d'y			stern A				
Physician		23a. Part I. Enter the disease of failure. List only one pause	compli	cations that carse	ed the deat	h. Do not enter t	he mode of dying	, such as cardiac o	or respiratory arre	st, shock, or l	heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease		Stab wour	d of c	hest						Death
<i>J</i> e		or condition resulting in death)		oue to (or as a cor	sequence	of):						
	ē	Sequentially list conditions, if any, leading to immediate	b.	oue to (or as a cor	sequence	of):						
12	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C.									
ted nsit	ž Ž	events resulting in death) Last	d.	oue to (or as a cor	sequence	of):						
be executed sician and urial - transit	dical	XUNPENDED		AMENDED i	tem#1 1	nerME o856	5 6/16/06 '	TT item#	23a.27.28a	-f.perM	E. 2856.	6/20/06 TT
50, te be a	Jed Jed	IF FEMALE:		23c. If yes, outc			0,0/10/00	11				0,20,00 11
Box 68760 e death certificate b the attending physic of for use as the bu	Physician/Me	23b. Was decedent pregnant in t past 12 months?	he	1 Live birth	offic of pre		etal death 3	Ectopic pregna	ancy	Month	of delivery Da	y Year
lox 6	S	1 Yes 2 No 9 V Un	known		at time of d	leath 5 O	ther (Specify)					
s, P.O. Bedires that the designed by the detached file.	5	Part II. Other significant condi		9 Unknown	ath but not	resulting in the	inderlying cause	given in Part I	23e Did tol	acco use co	ntribute to the	e cause of death?
P.C s that gned t		. art in ourse significant contain		or an Editing to do	atir but not	resulting in the	and only ing occusor	givoir in raiti.	1 Yes			
Division of Vital Records, P.O. and or Attending Physician: The law requires that the repeated that the arter of the result and Director. After this certificate has been signed by the funeral director, page 2 should be detachted.	Completed by								24a. Was a	n 24b	o. Were auto	psy findings available
COF law r has b									autops perform	sy		mpletion of cause of
Re- in The	3								1 ✓ Yes 2		1 🗸 Yes	2 No
ician ician s certi	ă	25. Was case referred to medica examiner?		ospital: 1 🗸 Inpa	tient 2	ER/Outpatient		e of Death (Check Other Nursin			Others	
of V ; Phys ter thi eral d	<u> </u>	1 Yes 2 No 27. Manner of Death		28a. Date of Ir (Month, Day		28b. Time of I		iry at Work?	28d. Describe h	Residence 6		
on Conting	5	1 Natural 5 Pen	ding				_ 1	Yes 2 X No	unk			
risic r Atte ter dez irecto n by ti	Ea	o V	stigatio	00 01 1		Find 8:4. nome, farm, stre	D pm et, factory, office t	building, etc.	28f. Location (S	treet and Nun	nber or Rura	l Route Number, City
Div urs aff	Certification:		rmined	(Specify) <u>f</u>	ound or	n street			Baltimore	ate) 1100 MD	Blk. Di	Route Number, City ruid Hill Av
		20a Cadifior	hysicia				rred at the time, d	late and place, and			ner as started	d.
o the vithin o the omple	Medical			On the basis of ex and manner state		and/or investiga	tion, in my opinior	n, death occurred a	at the time, date a	and place, and	d due to the	cause(s)
F × F 5	ž	29b Signature and title of certific					29c. Licens	se number		29d Date sig	gned (Month	h, Day, Year)
		Ay his,	mi				O.C.	M.E.		April 10,	2006	
		30. Name and address of person						VI				
IN DINO		Ling Li, MD Assista	int Me	dical Examin	er 11'	i ⊬enn Stree	et, Baltimore,	MD 21201				

IX pind

State 31. Date filed (Month, Day, Year) Registrar



-			1 - For State Registrar	State of Maryla	•	artment of <i>rtificate o</i>		nd Mental H	ygiene Reg. No. 0	16	11725
*	Physici	an	1. Decedent's Name (First, Middle, Las Sally S. Cl					2. Date of E Month April	Day	2006	3. Time of Death
) 	/Medic Examin		4a. Facility Name (If not institution, give	evenger		4b. City, Town	, or Location of			ty of Death	11:50a M
	LAGIIIII		Blakehurst Care C			Tows	on		Balt	imore	
12	Funeral		5. Social Security Number 6. Se	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Yea Months Day		Min. 8. Date of E (Month, I DEC 3	Birth Day, Year)	9. Birthpl Coun	ace (State or Foreign try)
不注	Director		228-14-3137 Usual Residence of Decedent	- 07	113.			DEG 3	1918		VA
	nyland how Lat		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10	Od. Inside City Limits
	8e-f	cto	MD Baltimo	re T	owson						1 ☐ Yes 2 🛣 No
	with the	Funeral Director	10e. Street and Number	1 A 20C		10f. Zip Code			10g. Citizen of		try?
	ne 23	era	1055 W. Joppa Roa	12. Was Decedent Ever in	U.S. 13.	2120 Was Decedent o	f Hispanic Orig	in? (Specify Yes or I		USA ace - America	
ဖွ	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 No		If Yes, specify Ci		Puerto Rican, etc.)		ack, White, 6	
003	ilied within 72 hours atter death with the Maryland Hygiene ther than "natural", or lieme 23a or 28e-f ehow hyt, the Madical Examiner must be notified at	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	10- 0				Speci	WII	ite
7	in 72 n "nat	plete	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most	of working	16b. Kind of I	Jusiness/ind	ustry
212	giene grant pr the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Libra	ariann			Publi	c Educ	cation
Maryland 21215-0036	be file ital Hy id oth	Be	17. Father's Name (First, Middle, Last)	C11.1 -				's Name (First, Midd		me)	
7	d Men marke	ပု	William Darby 19a, Informant's Name/Relationship (7)	Stoakley	19h Maili	nn Address (Stre	Em	ma Walla		n State Zin	Code)
Z S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Depertment if item 27 is marked other than "natural; or iteme 23a or 28e-f show evy injury or other traumetic event, the Madical Examiner must be notified at angle.		Ellen Clevenger-F					ng Drive,			27713
Baltimore,	es 1 a of Heg fitem r othe		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Dispo cemetery, cre	osition (Name of matory or other p	place)	Date	20c. Location	- City or To	wn, State
Ĕ	Pag tment tent: f		4 Donation 5 Other (Specify) Ch				/13/2006	Beltsv	ille,	MD
Bai	permit Deper Impor eny in		21. Signature of Funeral Service Licen	POOM MOOD	84 8	AFA, Sto	ephen D	. Lohrmanı	n, PA	MD	24.206
			23a. Part1. Enter the disease, or comp	olications that caused the de				ures Drive		n, MD	21286 Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line.		A.				4	Onset and Death
Jes S	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):	nge					years
84 P	Examine	100	Sequentially list conditions,	b. Due to (or as a cunsa	ouenne off						·
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to initire diate cause. Enter Underlying Cause (Disease or injury that initiated events		,440,100 017						
Ó	e exec en an	Еха	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	The law requires that the death certificate be executed the been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	dicai		d						-	
9	death certifica ettending ph d for use as th	/Me	IF FEMALE:	23c. If yes, outcome of preg	nancv				334 0	ate of delive	
Вох	death e etter d for u	iciar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3[□Ectopic pregnar □ Other (specify)			1		Day Year
P. O.	that the di ed by the detached	Physician/Me	9 🗆 Unknown	9□ Unknown							
	signed signed d be de	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause	given in Part I.		l tobacco use cor]Yes 2 □ No	ntribute to th	e cause of death? ably 4 \(\subseteq Unknown
Ö	w requir been si should	eted	Atail I hill.	tion				_			
Vital Records,	he lav e hes	Completed	Part firms	400				per	topsy formed?	prior to con death?	osy findings available inpletion of cause of
ital		Be Co	25. Was case referred to medical				26. Place	1 ☐ Yes of Jafth (Check onl)		1 🗆 Yes	2 NO
of <	Physici this ce al direc	2	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2[⊒ ER/Outpatie	nt 31 DOA		sing Home 5□Re	sidence 6 🗆 Ot	ther (Specify)
o uc	tending Ph death. tor: After th the funeral	ion:	27. Manner of D. III 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W	njuryat Vork? □Yes 2□N		e how injury occu	rred	
Division	or Attending Physicien: after death. Director: Atter this certifica in by the funeral director.	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At				28f. Location	(Street and Nurr	ber or Rura	Route Number,
á	o afte	Certification:	4 Homicide	building, etc. (Spec	cify)			City or T	own, State)		
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edical	(Check only 2 Medical Exam	ysician: To the best of my kininer: On the basis of examin	nowledge, deat nation and/or in	th occurred at the	time, date and y opinion, death	place, and due to the occurred at the time	e cause(s) and n e, date and place	nanner as st	ated. the cause(s)
	o the ithin 2 o the emple	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number		29d. Date sign	ed (Month, I	Day, Year)
	- s - ō) Bh	MD		λ	1882	22	4/1:	3/2/	
41	7		30. Name and address of person who	completed cause of death (Ite	эт 23а) (Туре,	Print)	100	11	18	1	,
7	00 10 Miles - 17		31. Date filed (Month, Day, Year)	11 na	Car	md Kd	, Ta	rklin/1	10 211	20	
	- Sta Registr		APR 1 4	2006 32. Hegistrar's Sign	15 19						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year TWILAH VIOLA DeFONTES 2006 13 4. 3:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE COUNTY BALTIMORE AUGSBURG LUTHERAN HOME If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
W. Va. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11-12-1923 **Funeral** 1 M ZAF 234-26-4155 82 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or items 23e or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🗙 No Baltimore County Director Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21237 USA 1615 Elligson Rd. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry Balto.County Board College (1-4or 5+) Elementary/Secondary (0-12) of Education Cafeterian 12 yrs. permit. Pages 1 and 2 should be flied v
Department of Health and Mental Hygies
Important: If item 27 is marked other tt
any injury or other traumatic event, Ifts
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ida Pearl Williams Irvin Ray Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 Elligson Rd. Baltimore, Maryland 21237 John D. DeFontes, Jr. (Son) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodsdale M. P. Cem. 4-18-2006 Grafton, W. Va. ' 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home €. 7. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7401 Belair Rd. Baltimore, Md. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE PARIKINSONS DISEASE 1 MONTH /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the use as I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 D'No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Junknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 2010 2 No 1 Yes 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) erel Director: After th filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation er death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after Dire 4 \ Homicide within 24 hours a To the Funerel C completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Dierce 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keights Avenue Baltimoro, MD 21208 16106 7220 raule 32. Registrar's Signature 31. Date filed (Month (BRYear) State 2006 4 Registrar

		ľ	For Stete Registrar	State of	Marylan	-	artmen rtificate				lental Hyg	giene Reg. No.	סטנ	And the second second	727
			1. Decedent's Name (First, Mid	idle, Last)							2. Date of Dea	ath Day		3. ear	Time of Death
н	Physicia /Medic		Charles Cl	ifford Deel	1						April,	11	200	-	:50 A M
	Examin		4a. Facility Name (If not instituti	ion, give street and num	nber)		4b. City,	Town, or	Location of	of Death		4c.	County of		
L			2209 Snow Ro	ad			Edg	rewoo	od.				На	rford	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	• •	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min,	8. Date of Birt (Month, Day	h v. Year)	9	Birthplace	(State or Foreign
	Director		227-28-1077	1 ⊠ M 2□F	79	Yrs.					Feb. 4		27 ر	/irgín	
	pu .	}	Usual Residence of Decedent 10a. State 10b. Coun	h	10c Cit	y. Town or Lo	nation							10d In	nside City Limits
	sho	ក		_											☐Yes 2 No
	he N	Director	Maryland Harf	ord	Ec	lgewood		0-1-				10. 0:::	(140		
	with page	급					10f. Zip		^			-		at Country?	
	eath	Funerai	2209 Snow Roa	12. Was Dece	dent Ever in III	6 12 1		21040		inin2 (Con	offu Vee or No	USA		American In	dian
	iter d	,S	11. Marital Status 1 ☐ Never Married 2 ☐ Ma	Armed For	ces?	.3.	f Yes, spec	ify Cuba	in, Mexicar	n, Puerto	cify Yes or No- Rican, etc.)			White, etc.	dian,
336	urs af	by	3 ₩ Widowed 4 □ Divorce	If You Give	e ites:		1□Yes 2	2 <mark>√</mark> No	Specify:				Specify:	White	Δ
21215-0036	2 hou	ed	15. Decede	ent's Education		16a. Deced	dent's Usua	I Occupa	ation		1	16b. Ki	nd of Busin	ness/Industry	
75	nin 7: In "ni Medi	Completed	(Specify only high Elementary/Secondary (0-12)	nest grade completed) College (1-	40r 5+)	(Give	kind of wor DO NOT us	rk done d se retired	during mos 1)	t of workii	ng			,	
21	d witi	E O	8) College (1	401 34)	Faci	$liti\epsilon$	es Ma	anage	r		U.S	. Gov	<i>r</i> ernme	nt
	be filed within 72 hours after death with the Maryland Ital Hygiene. d other then "natural; or items 23a or 28a-f show event. The Medical Examinat must be notified at	Bec	17. Father's Name (First, Middle	e, Last)							(First, Middle,				
ā	vid b Ments rked ric •	70 E	William Jenni	ings Bryan 1	Deel				Mil	lie	Mae D	uty			
Maryland	and hand		19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailir	g Address	(Street a	and Numbe	er or Rura	l Route Numbe	r, City o	Town, Sta	ate, Zip Code	9)
	and 2 salth n 27 i		Lisa Jirsa /	Daughter				_		Bel	Air, M	aryl	and 2	21014	
Ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation	2 Demonstra	20b. F	Place of Dispo cemetery, cres	sition (Nan	ne of ther place	e)	D	ate	20c. Lo	cation - Cit	ty or Town, S	State
Ĕ	Pag nent ant: i		`4 □Donation 5 □ Other		raio	Air M			1	4-1	5-06	Bel	Air,	Maryla	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event. The Medical Examination and other traumatic event.		21. Signature of Puneral Service	ce Licensee		Mc	Name and	d Addres	s of Facilit	ty Home	e, P.A.				
<u> </u>	\$9 E 29		JUJBy a	Muchs							, Abing	don.	Mary	land :	21009
г	100		23a. Part 1. Enter the disease, shock, or heart failure. Li	or complications that ca	used the deat	h. Do not ent	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	rest,		Appr	roximate rval Between
Щ	Physician		Immediate Cause (Final disease or condition			Hon	Fai	luvo						Onse	et and Death
	/Medical		resulting in death)	aDue to to	etive or as a conseq	uence of):	1111							- 1	CHIS
	Examiner		Sequentially list conditions	b. My	OCATE	LVA .	In far	ctio	n					7	ents
	ם ב	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (c	or as a conseq	neuce of):								= 1	
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		ron Ary		ry D	Bel	ase					4	cars
1760,	ate be executed nysician and he burial-transit	Œ	roodiling in coulin, case	Due to (d	or as a conseq	uence or):									
876	physic physic the b	dical		d.										-	
x 68	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outo											
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	rth 2 ☐ Feta	Ideath 3□	Ectopic pre					2	3d. Date o Month		Year
o.	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno	ant at time of d wn	eath 5L	Other (spe	өспу)							
<u>α</u>	that the de ed by the a detached f		Part II. Other significant condi	tions contributing to de	ath but not res	ultina in the u	nderlyina ca	ause dive	en in Part I		23e. Did to	bacco u	se contribu	ite to the cau	use of death?
ds,	signe d be	d by		, , , , ,		g	,					es 2[☐ Probably	4 Dinknown
Records,	w requir been si should	Completed													
že	e law has ye 2 s	mpi									24a. Was autop	sv	24b. Wei prio dea	r to completi	ndings available ion of cause of
											1 ☐ Yes	med2 2 2 No		Yes 2□1	No
Vital	ysician: iis certifica director,	Be	25. Was case referred to medic examiner?	Hospital:				A Othe			(Check only or				
ot	Phys this ral di	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date o		ER/Outpatien 28b. Time of		A Bc. Injury	4 🗆 140		ne 5 Resid 28d. Describe h			(Specify)	
u	ding Phy h. After thi funeral	tion	1 PNatural 5 ☐ Pend		n, Day Year)	Injury	M	Work	rati (? Yes 2.⊟I		.ou. Describe ii	OW IIIJuly	Occurred		
S	Attending Physician: r death. ector: After this certifici by the funeral director.	lica	3 Suicide 6 □ Coul	d not be	of Injury - At ho	ome farm str			, 00 2 0		28f. Location (S	treet and	l Number	or Rural Rou	te Number
Division	l or Attendater deatl Director:	Certification:	4 Homicide	mined 200. Flace buildin	g, etc. (Specifi	y)	oot, lactory	, omco			City or Tow			57 7 107 47 7 7 0 41	to rvamber,
_	e Hospital 24 hours a e Funeral letely filled		29a. Certifier 1 Certify	ring Physicien: To the	best of my kno	wledge, death	occurred a	at the tim	ne, date an	d place, a	and due to the o	ause(s)	and manne	er as stated.	
	24 h Fui	edical	(Check only 2 Medica one)	al Examiner: On the ba and mann	sis of examina	tion and/or inv	estigation,	in my op	oinion, dea	th occurre	ed at the time, o	date and	place, and	due to the c	cause(s)
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certif	ier			29c.	License	number			29d. Date	signed (A	Month, Day,	Year)
			× 3	renlin	mη			D.	3976	: 2		Apr	i) <i>i</i>	2,20	206
		- 1	re / un	renew	עויו			$-\boldsymbol{\nu}$	שוו כ	, J		Libl	31(ME	JU 10
	~ (1	Ī	30. Name and address of person	n who completed cause	of death (Item	1 23a) (Type.	Print)			_				,	
1	5+4		30. Name and address of person	n who completed cause	of death (Item										
1	5+4 Sta	te	30. Name and address of person	baum, m.	D. 20	12 Toll	ante				Be F				
1.	51 L Sta Registra	te ar	30. Name and address of perso	baum, m.	of death (Item D. 20	12 Toll	ante								

		-	State of Ma		artment of He	ealth and Mer Death	ntal Hygien	0006	11728
			Decedent's Name (First, Middle, Last)				Date of Death	a do me	3. Time of Death
E	Physicia /Medic	_	Charles Shipley Emeri	ck			April 13	2006	1:15 a.™
,	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		40	c. County of Death	rundel Co.
			North Arundel Nursing Home 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	1	Burnie	Date of Birth		place (State or Foreign
П	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Age	73 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Year 2C. 13, 1	932 Mai	ryland
	D		Usual Residence of Decedent	10 Ci T					10d, Inside City Limits
	anylar ehow	_	Maryland Anne Arundel	10c. City, Town or Lo					1 Yes 2 No
	the M	ecto	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cou	ntry?
	with be or	흐	615 Wardour Road		21061			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-f ehow minging or other traumatic event, the Medical Examinat must be nutified at ADE.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent E Armed Forces? 1 Wes 2 N If Yes, Give Year or Dates:		Was Decedent of Hi. If Yes, specify Cubar 1 ☐ Yes 2 【X No	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Ameri Black, White, Specify: Whi to	etc.
5-0036	2 hou atura ical E	ted	15. Decedent's Education	16a. Dece	edent's Usual Occupa	ation furing most of working	16b.	Kind of Business/Ir	ndustry
215	thin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	life.	DO NOT use retired,)	Ret	ail Sales S	Store
Maryland 2121	ed wi	် ပြ		' Secur	T Ly	18. Mother's Name (Fi			
and	ould be fil Mental H arked otl	Be	17. Father's Name (First, Middle, Last) Martin B. Emerick			Lettie Hugh			
<u> </u>	should nd Me mark imatic	၉	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street a	and Number or Rural Re		or Town, State, Zij	o Code)
	nd 2 salth ar 27 is r trau		Marjorie A. Emerick/Wife	615	Wardour Road	l Glen Burnie	Maryland	21061	
Baltimore,	Pages 1 and nent of Healint: If item		20a. Method of Disposition 1 Buriai 2 Coremation 3 Removal from State 4 Donation 5 Other (Specify)		osition (Name of ematory or other place rvice Corp.	Pate 4/14/06		Location - City or T Son Maryland	
Balti	permit. Departn Imports eny inju		21. Signature of Funeral Service Licensee Christina Chuotina L. Hulto	L. Hilton 2	22. Name and Address Leonard	ss of Facility J. Ruck, Ir		05 Harfor Itimore,	
	Physician /Medical Examiner	ner	Sequentially list conditions b	a consequence of):	arcene		Pacs te	te	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physicien and ed for use as the burial-transit	ical Examiner	that initiated events c.	a consequence of):					
P.O. Box 68	death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnancy			23d. Date of delik	rery Day Year
	iaw requires that the as been signed by th 2 should be detache	Þ.	Part II. Dther significant conditions contributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tobacco		the cause of death?
Division of Vital Records,	S S	Completed	retopionteneal	lyn	ph n	odes	24a. Was an autopsy performed?	death?	opsy findings available ompletion of cause of
ital		BeC	25. Was case referred to medical			26. Place of Death (C			
_	Physician: this certific ral director,	70	examiner? 1 ☐ Yes 2 ★No Hospital: 1 ☐ Inpatie			4/2 Nursing Home		6 ☐ Other (Spec	ify)
ion o	ding After fune		27. Manner of Death 1 Anatural 5 Pending (Month, Date of Injugation) 2 Accident investigation	ry Ye <i>ar)</i> 28b. Time Injury	Wor	Yes 2 □ No	I. Describe how in		
Divis	or Al fter c jirec in by	Certification	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injuiting, et	jury - At home, farm, s c. <i>(Specify)</i>	street, factory, office	28f	Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st.	of examination and/or ated.	investigation, in my o	pinion, death occurred	at the time, date a	and place, and due	to the cause(s)
	To the within 2 To the complex	Σ	29b. Signature and title of certifier band elen	vol, MD.	29c. Licens	e number 0298 73 i4, #610,	29d. [Date signed (Month	n, Day, Year)
_	þ		30. Name and address of person who completed cause of a RITA LHAN DELW AL, 10	death (Item 23a) (Type 6 co S - C	e, Print) PAIN HU	4, 4610,	GLEN	510 BURNE	BI Md.
	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 1 4 2005	rar's Signature	soli)				
DI	HMH 17 Rev 1/	2001		6					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 10.55PM **Physician** HUMPHREY FOUTZ 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA OUTZ HUMPAR BALTIMORE LOCHRAVEN NURSING HOME 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02.0). 1933 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Months 1**Ø**M 2□F 13 452·48·0280 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other than "nature!" any injury or other traumatic average. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No Director GWYNN MO BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 USA 4602 SPRINGDALE AVENUE 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 🗹 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 Ho Specify: þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MINISTRY PREACHER YRS 12 TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MCCRAY CHARLIE FOUTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4602 SPRINGDALE AVE. BALTO. MD 21207 (WIFE ANNIE J. FOUTZ 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ■ Burial 2 Cremation 3 Removal from State 04.22.06 BALTIMORE, MO * 4 ☐ Donation 5 ☐ Other (Specify) MOODLAWN 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licens 5151 BATTO. NATE PIRE, BALTO. MO 21229 aughn Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Q re Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 McUnknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has 2 No 1 Yes 2/2 No 1 TYes Hospital or Attending Physician: 24 hours after death, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No P After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 1. Natural 5 Pending 1 🗌 Yes investigation 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide determined filled in by 4 \ Homicide To the Hospital within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

10

31. Date filed (Month, Day, Year)

ORIGINAL

500

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year Month Physician Mary Elizabeth Fredrick 2006 April 10:46 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vantage House Columbia Howard If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year, **Funeral** Months Deys Hours 1 ☐ M 2 ⋤ F 231-58-2407 Delaware Director 84 14,1921 Aug. Usuel Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Merylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Directo Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 5400 Vantage Point Road Apt#408 21044 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 ☑ No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) end Mentel Hygiene. Ie merked other than Elementary/Secondary (0-12) College (1-4or 5+) Nurse U.S. Navv 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Floyd Turner Nettie Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 5400 Vantage Point Road Apt#408 Columbia, MD 21044 Health Charles Fredrick item 27 (Husband) 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremetion 3 ☐ Removel from State Metro Crematory 4 Donetion 5 Other (Specify) 4-11-06 Catonsville, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Fecility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner sete has been signed by the ettending physician end page 2 should be deteched for use as the buriel-trensit the Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as e consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗆 Yes After this certificate completely filled in by the funerel director, 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28b. Time of 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigetion 1 Yes 2 No 2 Accident within 24 hours efter death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 413 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

ORIGINAL

		•	For State Registrar	State of Marylan		artment of F		Mental Hy	giene	HHI	11731
	Physici		1. Decedent's Name (First, Middle, L.	Joseph		FULL	eR	2. Date of Do	eath Day	Year Job	3. Time of Death
	/Medio Examin		011	ve street and number) L Co		BA	Ltimue	و		County of Dea	
	Funeral Director			Sex 7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Year)	, C	thplace (State or Foreign ountry) Maryland
	show	ž	10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes ※☐ No
	h the M or 28a-f	Director	Maryland Howard 10e. Street and Number	Han	over	10f. Zip Code			10g. Cit	izen of What C	
	ath will	ralD	6035 Hanover Rd.			21076			USA		
036	ours after de et', or items Frankrer it	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ⊠Yes 2 □ No 42- If Yes, Give Year or Dates:	42	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0-	14. Race - Am Black, Whi Specify: W	
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other traumatic event, ite Medical Engines must be notified at ance.	Completed by Funeral	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of we	orking	16b. K	ind of Business	/Industry
rland 2	uld be filed Mental Hygi irked other itic event, II	To Be Co	17. Father's Name (First, Middle, Las John Fuller	it)	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		18. Mother's Na Minnie	me (First, Middle Hardy			
Mary	d 2 sho th and h ty ie ma trauma	. 1	19a. Informant's Name/Relationship Harbara Boqdan-da		4	ng Address <i>(Street</i> Hanover			-		Zip Code)
Baltimore,	Pages 1 en nent of Heel nut: if item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	20b. P	Lace of Dispo emetery, crei	sition (Name of natory or other place Memorial F	ce)	Date	20c. Lo	ocation - City o	
Balti	permit. Depertrimporte eny inju		21. Signature of Funeral Service Lice	Mol234	22	Name and Addre Sary L. K 7250 Wash	ss of Eacility aufman E ington E	Tuneral I	Home lkric	at MMP dge, MD	, INC , 21075
			23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final	riplications that caused the death y one cause on each line.	n. Do not ent	er the mode of dyir	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	uence of):	^					
	3	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Myocardio Due to (or as a consequ	uence of):	archor)		· · · · · · · · · · · · · · · · · · ·		
8760,	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	uence of):						
9	tificate og phys as the	ledic		d				-,			
P.O. Box	he death certific / the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	y			23d. Date of de Month	elivery Day Year
	v requires thet the de been signed by the a should be detached f	þ	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause gw	ven în Part I.			use contribute t	to the cause of death?
Il Records,	The ate h	Completed						24a. Wa: auto perf 1 ☐ Yes	ormed?	prior to death?	
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Division of Vital	Attending Physic death. actor: After this by the funeral di	ation; To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injui	4 Nulsing	Home 5 Res			ecny)
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	To the Hospital or Attending I within 24 hours effer death. To the Funerel Director: Atter completely filled in by the funer	edical (29a. Certifier 1 To Certifying F (Check only one) 2 Medical Exe	Physicien: To the best of my kno eminer: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	opinion, death occ	curred at the time	, date and	d place, and du	e to the cause(s)
	To the within To the comple	¥	29b. Signature and title of certifier			29c. Licens	se number		29d. Da	te signed (Mor	ith, Day, Year)
,	j.		30 Name and address of person who	Section of the sectio	1920\ /T =	Print	7475		A	PEIL	11 2006
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	Sta Registi		APR 1 4 20	and manner stated. Chen M Registrar's Signa	ture						

Physician //Infedical Examiner As. Facility Name (If not institution, give street and number) Saint Joseph Medical Center Funeral Director Funeral Dire	Reg. No. 0 6 a of Death th Day Ye RIL 11 20 4c. County of E Ba a of Birth nth, Day, Year) - 2(6 - 1905 B	Death It imore Birthplace (State or Foreign Country) ALTIMORE, ML 10d. Inside City Limits 1 Yes 2 PM American Indian, White, etc. White
Physician Medical Examiner 1. Decedent's Name (First, Middle, Last) 2. Data Mode Medical Examiner 3. Packet Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 11. Under 1 Year	a of Death th Day Ye RIL 11 20 4c. County of E a of Birth nth, Day, Year) - 2(c - 1905 B 10g. Citizen of Wha US s of No- alc.) 16b. Kind of Busin Calvor +	Death It imore Birthplace (State or Foreign Country) HLTT MCRE, ML 10d. Inside City Limits 1 Yes 2 PM American Indian, White, etc. White
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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Informant's Name/Relationship (Type, Print) 19. Informant's Name/Relationship (Type, Print) 19. Mailing Address (Street and Number or Rural Route of Disposition (Name of Commetery, crematory or other place) 20a. Method of Disposition 1 VBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Middle, Maiden Sumame)	N. 111.
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TUNING AUTOLOGY EVANS FUNSIFIC HAPPEL	8800 HARFOR	
23a, Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responsively.		Approximate Interval Between
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v : 58 COPONARY ARTERY DISEASE	• 1	Probably 4 Unknown
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	29d. Date signed (A	fonth, Day, Year)
A. J. Helory M. 13- D0017695	(Inail)	11 2 00/
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	FIPUX "	11,2006
ABDALLAH J. HELOU, MD. 7601 OSLER DRIVE. TOWSON, M	FIPUL	11,2006
State Registrar 31. Date filed (Month, Day, Year) APR 1 4 2006 Registrar's Signature	ARYLAND 2	1204

			. For			nt of Health and	•	•	1 1 77 0 0
_			For State Registrar		Certifica	te of Death	Reg. I	No. UUO	11/33
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	ath erine	Gude	12	April	Day 2006	3. Time of Death 415 A M
9	Examir	ner	4a. Facility Name (If not institution, give s Upper Che Sapea	ke Mod. Co	u te 1 4b. Cit	y, Town, or Location of Deatl	n i	Har Force	/
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	Nonth:	ler 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthol	lace (State or Foreign trv)
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	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28e-f ehow ta Modical Exertirer must be nutilied at	tor	10a. State 10b. County HARFOR	10c. Ci	ty, Town or Location Bel Ai			10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
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3	r death	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - America Black, White,	
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04 15	hin 72 h e. n netu Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	sual Occupation work done during most of wo use retired)	rking 16b	. Kind of Business/Ind	lustry
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13/c6 Maryland	2 should be filed within and Mental Hygiene. is marked other then eumatic event, Italia	F	19a. Informant's Name/Relationship (79)	pe, Print)	19b. Mailing Addre	ss (St. et and Number or Ri	ural Route Number, Cit	y or Town, State, Zip	Code) 21014.
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Hol 4	permit. Page Department Important: if any injury o		4 ☐ Donation 5 ☐ Other (Specify)	Fin	ns Funcial	Chapat Belfic	4-13-06 F	orest Hi	11, MD
3.	Department of the control of the con		21. Signature of Funeral Service License	An total		and A dress of Facility Fo	RESTHIC	LMOZK	ISTO
の445401 Balli			23a. Part1. Enter the disease, or complishock, or heart failure.	c tions that caused the dea	th. Do not enter the m	ode of dying, such as cardia	c or respiratory arrest,	The second secon	Approximate Interval Between
Š	Physician		Immediate Cause (Final disease or condition resulting in death)	METHICIUS,	N RESISTI	ANT STAPH I	SUREUS S	EVERE.	Onset and Death
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77 89	certificat nding phy use as the		IF FEMALE:						
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9 THERIN	law requests been 2 should	Completed					24a. Was an	24b. Were auto	psy findings available
HE	The lav ate hes page 2	mo.					autopsy performed		mpletion of cause of
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	Phys or this oral dir	5 7	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 1 1 28b. Time of	28c, Injury at	Home 5 Residence		0
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) SS /	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		ory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
27	Hospii 24 hour Funer letely fill	Medical	29a. Certifier (Check only one) Certifying Physical Exami	ner: On the best of my kn ner: On the basis of examin and manner stated.	cwladgs death acnum ation and/or investigation	ad at the time, date and plan on, in my opinion, death occ	a and dus to the naus urred at the time, date	a(s) and manner to se and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	Lithe		29c. License number 26.19		Date signed (Month,	
	109		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, Print)	D26 19 1 n pr pos, sur	TE 10 FAL	LSTON, MZ	021047
	St Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	be the second	,,,,,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** MA COE: hoddric am 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kandallsto If Under 1 Year | If Under 24 Limizze 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 4 2 F Days Min 177-22-4201 Usual Residence of Decedent Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. is marked other then "naturel", or iteme 23a or 28a-f ehow raumatic event, the Medical Examinant routing at 1 Yes 2 No salti more Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 Funeral Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Couldre (1-4or 5+) ngineer Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be 19b. Mailing ddress (Street) nd Nug Town, State, Zip Code) Depertment of Heelth a Important: If Item 27 is eny Injury or other tree one 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Limbsee vices 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Embolas pue to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons a uence of): Examine ettending physician and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the et d be deteched fo 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes b lirector, page 2 s autopsy performed 2□ No 1 ☐ Yes within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and clade and due to the cause(s) and mixing ras stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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4 2006

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marviand / Becarement of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Joan Harriet Stacy Gravatt Day Feb 7,2006 6:30am Joan Harriet Stacy Cravett 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Bethesda Montgomery Suburban Hospital 9. Birthplace (State or Foreign New Jersey If Under 1 Year If Under 24 Hrs. 8. Date of Birth July 20, 1916 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Months 1 ☐ M 2 🗓 F 89 Yrs 040-14-9443 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County TX□Yes 2□No Bethesda MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20817 United States 6319 Kenhowe Drive 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Foreign Affairs Officer US Govt 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Grace Harriet Lipsius Henry Eckford Roberts Stacy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6319 Kenhowe Dr., Bethesda,MD 20817 Robert H. Gravatt III 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 4-19-06 Washington DC Glenwood Cemetery 22. Name and Address of Facility of Funeral Service Lig 21. Signature Joseph Gawler's Sons, INC 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. 5130 Wisconsin Ave, N.W. Washington DC 20016 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 Days Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown C. Difficile Colitis 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 🛛 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Ž No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of

1 ☐ Yes 2 ☐ No

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D35941

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 7,2006

Physician /Medical Examiner

Examine

Physician

/Medical

Examiner

10a State

Director

Funeral

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Completed

Be

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show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Depertment of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examiner must be notified at

3altimore, Maryland 21215-0020

the Marylend

physician and s the burial-transit as attending p signed by the a Id be detached f certificate has been si irector, page 2 should funeral director. After this

The law requires that the death certificate be executed Hospital or Attending Physicien: ierel Director: A To the Hospital within 24 hours a To the Funerel Completely filled

Division of Vital Records, P.O. Box 68760,

Physician/Medical ģ Completed Be Certification: To

edicai

State Registrar

30. Name and addres Maphary to completed cause of death (Item 23a) (Type, Print)
Puran P. Hajhur 50 W. Edmonston Dr. #401, Rockville, MD 20852

1 XNatural

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be determined

M.D

4

2005

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95

	•	For State Registrar	State of Maryl		epartment of F Certificate of			giene	6 11736		
Physicia /Medic	al	Decedent's Name (First, Middle, Las	Galla	ghe	4b City Town o	r Location of Dea	2. Date of De Month		Year 00 12,50pM		
Examin Funeral Director		5. Social Security Number 6. So	Brightwood Center				utherville s. 8. Date of Bir	th ly, Year)	Baltimore 9. Birthplace (State or Foreign Country) Rochester, New		
ryland		10a. State 10b. County	10c.	City, Town	or Location			10d. Inside City Limits			
the Marylar 28a-f show	ecto		timore			wings Mills			1 □ Yes ₹ No		
ath with t	Funeral Director	10e. Street and Number 4813 Shellbark Rd.			10f. Zip Code	21117		10g. Citizen of W	U.S.A.		
in a straight of the Maryland straight of the Maryland strand Schould be filed within 72 hours after death with the Maryland it has the and Mental Hygiene. It has the marked other then "naturel", or iteme 23e or 28e-f show other traumatic svent, the Maryland Examination at the mailified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 Ves 2 □ No If Yes, Give Year or Dates:	2076 1984	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)	Specify:	- American Indian, k, White, etc. White		
natu natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's Usual Occup (Give kind of work done	during most of w	orking	16b. Kind of Bu	siness/Industry		
ally allowed the state of the s	duic	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retire	ு nce Adiuste	Ar.		Insurance		
y called A lead with Mental Hygiene arked other than attic event, Irea	Be Co	17. Father's Name (First, Middle, Last)	4		Ilisula		:I ame (First, Middle	, Maiden Sumami	9)		
denta Aenta riked tic sv	To B	Georg	e Shelbv				V	/irginia Scot	t		
2 should and Men is marks aumatic	-	19a. Informant's Name/Relationship (7		19b.	Mailing Address (Street	and Number or F					
permit. Pages 1 and 2 Depertment of Health Important: If Item 27 sny injury or other tr.		Ms Erin Gallagher 20a. Method of Disposition	20	b. Place of cemeter	7021 Lachlan Disposition (Name of y, crematory or other place		more, MD 21 Date		City or Town, State		
Pages ment of l ent: if lit		1 ☐ Burial 2 ☐ Scemation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Rayview Cremato		4/10/2006	В	altimore, MD		
permit. Pages Depertment of Important: If It sny injury or o		21. Sign Arr of Funeral Service 1 control of Service 2 control of Funeral Service 2 control of Service 2 control of Funeral Service	blications that sed the o	11792	22. Name and Addre	ss of Facility Funeral Hor	ne, P.A. a Pike Ellica ac or respiratory a	tt City, MD 2	Approximate Interval Between Onset and Death		
cate be executed / Medical Examiner / Medical Examiner / The prival-transit / The prival-tran	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. Of the Funerel Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditions or	23c. If yes, outcome of pre 1	etal death of death	3 Ectopic pregnancy 5 Other (specify)		23a Dirtt	Mor	e of delivery th Day Year		
requires t	ted by		Simbaling to doubt but hot	TBSUILING III	the discerning cause gre	en mir que,	1 🗆		3 Probably 4 Unknown		
iclen: The law certificate has b	e Completed	25. Was case relerred to medical				20. 81	1 ☐ Yes	primed? d 2 No 1	Vere autopsy lindings available rior to completion of cause of eath? ☐ Yes 2☐ No		
ysicie	0 B	examiner?	Hospital:	2 □ ER/Out	tpatient 3 DOA Oth		eath <i>(Check only o</i> Home 5 ☐ Resi		or (Specific)		
Unter Hospital or Attending Physicien: The la within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director. page 2	Certification: T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea.		ime of 28c. Injury			how injury occurre			
tal or Att	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, Iai ecify)	rm, street, lactory, office		281. Location (City or To	Street and Numbe wn, State)	er or Rural Route Number,		
ne Hospi n 24 hou he Funer bletely fill	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge nination and	, death occurred at the tild For investigation, in my o	me, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)		
To t To t com	×	29b. Signature and title of certifier	n		29c. Licens	o number		_	(Month, Day, Year)		
10		30. Name and address of person who	m 7501	030		TON	sow in	0 712	oy		
Sta Registr	-	31. Date liled (Month, Day, Year) APR 1 4	32. Registrar's S	gnature	The same of the sa						
DHMH 17 Rev 1/20	001		2006	OF	RIĞINAL						

Funeral Director

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

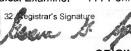
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

Baltimore, MD 21215-0036

	1- For State	tate of Maryl	***************************************		Health	Land			giene	Reg No	200	/~ F*\	1173
n/	Registrar 1. Decedent's Name (First, Mid-	dle,Last)						2	2. Date of D			3, Time	e of Death
er	Alisha Sama	ntha Hai	ncock						April 10	, 2006	Year	3:3	35
	4a. Facility Name (if not institut	ion, give street and n	umber)	4	b. City, To	wn, or Lo	ocation of	Death		4	c. County of Dea	th	
	Howard County Gen	eral Hospital			Colum	bia					Howard		
	5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under	T	If Under	24Hrs. Min.	8. Date of	Birth (MN	M/DD/YYYY) 9. B C	irthplace ountry)	(State or Foreign
	213-75-7395 Usual Residence of Decedent	1 M 2 X F		Yrs.	1	21			02/2	20/20	006		MD
	10a. State 10b. County	,	10c. City,	Town or Location	on							10d. lr	side City Limits
_			-									1 X	Yes 2 No
양	MD 10e. Street and Number		Ва	11timore	code				10g. Ci	untry?			
ire											,		
ᆵ	826 Glade Cou		cedent Ever in U.S	12 14/04	21225 13. Was Decedent of Hispanic Origin? (Sp					No	USA	uiana Indi	ion Block
ner	[TT]	Married Armed F	orces?		s, specify					NO-	14 Race - Ame White, etc.	encan ind	ian, black,
교		1 Yes ivorced If Yes, Give Ye	2 X No	1	Yes 2	No.	e nocifu:				Specific D.1	1_	
Ş	15. Decedent's Education (Sp	or Dates:	1	16a. Decedent	Long			nd of wo	rk done	16h	Specify: B1 Kind of Business		
ted	Elementary/Secondary (0-12			during			•		AR GOILE	100.	Killa of Basilloss	will ladd out y	
훒	0	, 55.1.535	(, , , ,		orking life ever		5	ea)					
Be Completed by Funeral Director	17. Father's Name (First, Middl	e, Last)		14.6	EVEL			Name (First, Middl	e, Maide	n Surname)		
ě	Sean Hancock	· ,						•	LSimr		,		
ToE	19a. Informant's Name/Relation	nship (Type, Print)		19b, Mailing	Address	(Street					City or Town, Sta	te, Zip Co	ode)
-	Sean Hancock/			2847	Spel	1man	Road	d F	Baltin	nore.	MD 21	225	-1
	20a. Method of Disposition	rather	20b. F	Place of Disposit	-				Date		Location - City o		State
	1 Burial 2 X Crematic	on 3 Removal	il Olli Otato	rematory or oth									
	4 Donation 5 Other		Me	etro Cre					13-06		Baltimo		
	21 Signature of Funeral Service	Cicensee	0_								ton & So		
	23a. Pat I. Enter the disease, of	1. /	MODE OF THE PROPERTY OF THE PR		701-3						nore, MD		217 oximate Interval
	alure. List only one caus	e on each line.						ulac of 1	respiratory	allest, si	lock, of fleat		veen Onset and
	Immediate Cause (Final disease		n unexplai:		in in	fancy	7						Death
	or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):												
Ļ	Sequentially list conditions, if any, leading to immediate		a consequence of	Α.									
dical Examine	cause. Enter Underlying Caus	e	a consequence of	,									
xan	(Disease or injury that initiated events resulting in death) Last	D = 1= (=====	a consequence of	·):									
Ē		d.											
ë	X UNPENDED	AMENDED	item # 2	3a,27,28a	-f,per	ME,g8	355,5/	15/00	5 TT				
	IF FEMALE:		, outcome of pregr	nancy						2:	3d. Date of delive	ery	
jan/	23b. Was decedent pregnant in past 12 months?	I	birth		al death	3	Ectopic p	oregnan	icy		Month	Day	Year
Sici	1 Yes 2 V No 9 U	nknown -	nant at time of de	ath 5 Oth	ner (Specif	fy)							
ř	Part II. Other significant cond		nown	eulting in the u	ndorluina a	oueo di	on in Part	-	220 Di	d tabasas	o use contribute t	o the cou	so of death?
Š	Part II. Other significant cond	intons contributing	to death but not re	saiding in the di	indenying c	ause giv	eninran					obably 4	
eq												,	
Be Completed by Physician/Me									24a. W	as an Itopsy			ndings available on of cause of
E									1 ✓ Ye	erformed?	No 1		2 No
ŏ	25. Was case referred to medic	cal			26	S.Place o	of Death (0	Check or	nly one)				
ă	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DO	A O	ther ₄	Nursing	Home 5	Resid	dence 6 🗸 Oth	er: Scene	
٠ <u>.</u>	07 M	28a. Date	e of Injury th, Day,Year)	28b. Time of Ir	jury 28		at Work?			be how ir	njury occurred		
Ö	1 Natural 5 Pe		4/10/2006	Fnd 2:20	ΔM	1 Ye	s 2 y	No ,	ınk				
cat	2 Accident Inv	restigation	ice of Injury - At ho			office bui	Idina etc			n (Street	and Number or F	Rural Rou	te Number City
ŧ	3 Suicide 6 X Co	termined (Specify	II		.,,,			4	or Tow	n, State)	3142 Norm	andy V	Woods Driv
Medical Certification:	4 Homicide 29a. Certifier 1 Certifying	Physician: To the be		ge, death occur	red at the t	ime, date	e and plac				City, MD and manner as st	arted	
dica	(Check only one) 2 Medical Ex	caminer:On the basis	s of examination a										e(s)
Me	29b. Signature and title of certi	and manner fier	stated.		29c.	License	number			29d	I. Date signed (N	fonth, Daj	y, Year)
_	Qual	7 -	MD			O.C.M					oril 11, 2006		
	ana		1 118			2.4.11				, ,	, _555		
	30. Name and address of person				treet D	altimo-	a MD 3	1201					
	24 Date Stad (Marsh Con Ver	ssistant Medical		111 Penn S	ueet, Ba	aumor	e, MD Z	. 1201					
ate		4 2006	egistrar's Signatu	e Anna	L'I								
rai	HINT.	7 COOO	ARTHUR DE		-								
001				ORĪGINAI	-								



DHMH 17 Rev 1/2001 OCME 10/2003

State Registrar

20b. Place of Disposition (Name of cemeter), Date 20c. Location - City or Town, State 04-15-06 Lansdowne Md MARYLANS 21. Signature of Funeral Service Licensee

22. Name and Address of Facility BROWN JR. FUNERAL HOME

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

Approximate Inter Approximate Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No Other Nursing Home 5 Residence 6 Other 28d. Describe how injury occurred Subject cut and stabbed 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3300 Old Frederick Road, Baltimore, Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c, License number 29d Date signed (Month, Day, Year) O.C.M.E. April 11, 2006 30. Name and address of person who completed cause of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Registrar's Sign 31. Date filed (*Month, Day*, Year) **APR 1 4 2006** Circulus A **ORIGINAL**

MA

14. Race - American Indian, Black,

BOONE

Specify: BLACK

MARYLAND

10d. Inside City Limits

1 X Yes 2 No

State Registrar

OCME 10/2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend Item #17 Per FH g854 4/11/06 JH Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 8:00 AM **Physician** 2006 4 Hooper /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Balt imore SSCX Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birtholace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 MM 2□ F 0 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or items 23e or 28e-f show the Medical Examinar must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 15H Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11, Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates Arm þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) Electriciar or other traumatic svent, 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17 Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Tolm, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Depertment of Health ar
Important: If Item 27 is
sny injury or other trau Marie reek Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20d. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (SpeClfy) 21. Sonature of Funer I Savice Li + nsee 22. Name and Address of Facility ans uneral chapel mD 2/234 rd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year Pnysician CANCER ESOPHALEAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed ng physiclen and as the burial-transit Due to (or as a consequence of): Physician/Medical attending to for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctooic oregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the all d be detached for 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown should should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificete has b lirector, page 2 si autopsy 1 ☐ Yes Division of Vital Attending Physician: 26. Place of Death (Check only one) director, Medical Certification; To Be 25. Was case referred to medical 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Tes within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending 1 🗌 Yes 2 No investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -51555 4-12-06 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) Balto. MD. 21237 Dr. Suite 2200 Sein Hung, 1 31. Date filed (Month, Day, Near) 103 Franklin m.D

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State
Registrar Amend ITem #23b Per Phy g85 Certificate of Peath Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 6:12PM Sladys 2006 April /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 25 F 70 220-30-6235 MD 10~27-35 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, I're Modical Examinar must be notified at 1 XYes 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1717 Bank St. 21231 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11 Marital Status be filed within 72 hours after de tal Hygiene. d other then "naturs!", or Item 1 ☐ Yes ANO If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Whiter 1 ☐ Yes 2 X No Specify: þ 3√2 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Laborer 9th 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if Item 27 is marked other
any injury or other traumatic event. 17. Father's Name (First, Middle, Last) Edith M. Goetz Robert L. Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1717 Bank St. Balto. MD 21231 Beverly Hughes 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-11-06 Dundalk, MD Bayview Crem. 22. Name and Address of Facility Wesley Chavis, Jr. FH 21. Signature of Funeral Service Live see 2007 Eastern Ave. Balto., MD 21231 23a. Part1. Enter the disease, or complications that cauded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Library one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** made rinary /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 28 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🛣 No 1 X Inpatient nours after death.

neral Director: After this filled in by the funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral Completely filled 1x Certifying Physician: To the best of my knowledge death occurred at the time date and plane and due to the nause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and all P19694 dress of person who completed cause of death (Item 23a) (Type, Print) Dittorn MO 22 South Greene Street Registrar's Signature 31. Date filed (Month, Day, Year) APR 1 4 2006

State Registrar

		Please	Type or Print in Black In State of Maryland / Depart		-	-					
		State Registrar		rtificate of Death	Reg	2. 006	1 / 4				
Physicia /Medic		Decedent's Name (First, Middle, Lase Blanche H	offmann		2. Date of Death Month April 12	, 2006 Year	3. Time of Death 9:00 P M				
Examin	_	4a. Facility Name (If not institution, give Gilchrist	e street and number)	4b. City, Town, or Location of Death		4c. County of Death Baltimor					
Funeral		5. Social Security Number 6. S	3 1 7	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	Q Rieth	place (State or Foreign				
Director	}	212-03-5669 Usual Residence of Decedent	□ M 2 X F 92 Yrs.	Months Bays Trodis Mills	Nov. 16,	1913 Mary	land				
nyland show		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits				
the Ma 28a-f	Director	Maryland Baltimo 10e. Street and Number	re Towson	10f. Zip Code	100	. Citizen of What Cou	1 ☐ Yes 2 ☐ No				
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2 shoul and Me Is mark	ဥ	19a. Informant's Name/Relationship (ity or Town, State, Zij	Code)							
1 end 1 Health em 27 ther tr		Catherine Kowalew 20a. Method of Disposition	JSKi / Friend 601		owson, Md	. 21 204 c. Location - City or T	own State				
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permit. Departm Importa		21. Signature of Funeral Service Licer	25	2. Name and Address of Facility	= 000 000 000 = 0 = 000 000 000 = 0	1050 Yo	rk Road				
0 0 7 € 0		23a. Part1. Enter the due on, or		Ruck Towson Funera ter the mode of dying, such as cardiac			Approximate				
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/Medical Examiner		resulting in death)	Due to (or as a consequence of):	my Sorrena	0 000	CARROLL					
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aw requir as been si 2 should	ompleted	//			24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of				
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Attend r death octor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not b	28e. Place of Injury - At home, farm, st	M 1 ☐ Yes 2 ☐ No		et and Number or Rur	al Route Number,				
ital or ral Dire led in t		4 C Hornicide	building, etc. (Specify)		City or Town,	State)					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only one) Certifying Pl	hysician: To the best of my knowledge, deal miner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occur	and due to the caused at the time, date	se(s) and manner as a and place, and due to	stated. the cause(s)				
To the To the Comp	ž	29b. Signature and title of certifier	00 1	29c. License number		Date signed (Month,					
1	1	30. Name and address of person who	completed cause of leath (Item 23a) (Type,	D25205 N. Chales Si	L. Ral	of ms	7000				
Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	P and							
Registr	ar	APR 1 4 2006 Been St Aprile									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#PI,lineb perMD, 0354 114/06 TT Department of Health and Mental Hygiene Certificate of Death Rag. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 5:25 A M **JARVIS** MAXINE 2006 04 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD FOREST HILL FOREST HILL HEALTH & REHAB CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 F 9, 178-24-9504 79 Dec. 1926 North Carolina Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 7 is marked other than "natural", or Itame 23a or 28a-f show traumatic event, the Medical Examinar must be collided at 1 Yes 2 No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 USA 109 Forest Valley Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after neat of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Ite ury or other traumatic event, the Medical Examina Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: 1 Yes 2 No þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clothing Manufacturer Seamstress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edwards Jarvis Bessie (nmn) Solomon Bruce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1716 Morse Road, Forest Hill, MD 21050 Freeda Eagle / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Bel Air Memorial Grdns 4-13-06 Bel Air, Maryland 4 ☐Donation 5 ☐ Other (Specify) 21. Signatu McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** 70 THUR e Due to (or as a consequence of): /Medical Examiner Parkinsons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a curisuquence of) Examiner attending physicien end for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► No 24a Was an page 2 s 2 200 certificete 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one Other: ANursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☒ No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funerel Dire 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April 11 2006 035523 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MD 21014 31. Date filed (Month, Day, Year) Registrar's Signature State APR 1 4 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 State of Manyland/1090 artinent of Health and Mental Hygiene em #20b&c Per FH G854 4/14/06 JH Reg. No. 2 Date of Death Month Year **Physician** JOHNSON 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HAYERSTOWN WAShington CH HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 11/91/16/11/948 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F 216.76.3476 Yrs Director MO Usual Residence of Decedent the Maryland 10a State 10b, County 10c. City, Town or Location 10d. Inside City Limits in then "netural", or iteme 23a or 28e-f ehov The Medical Examiner must be notified at HAGERSTOWN WAShington MID 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13532 RED BRICK LANE 21742 45 Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: B/K 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DISABLED i. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: if Item 27 is marked other tigury or other traumatic event. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHNSON EISIE MAE FLANAGAN THOMAS 4. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE,MI. ZIIT 49 High FALCON Rd. SISTER NORRIS Ohur E Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State MERGOWT TORE OCERIACE Surial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 4 Donation 5 Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PHILLIPS FUNERAL HOME Thech CESP. CPC 1721-27N. MONROEST. BACTIO, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dysohylhmia **Physician** Cardiac /Medical Due to (or as a consequence of) Examiner Renal Mronic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) pertension The law requires that the death certificate be executed as the burial-transit Due to (or as a onsequence of) IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy jo Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | ☐Yes 2☐No page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à of Vital Records. Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medicai Certification: To 1 In patient 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No s after death 2 Accident 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide pellil Hospital 24 hours 1 Contitying Physician: To the best of my knowledge ideath occurred at the fine idea and place, and due to the dause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 2 ş 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2060336 04/10/06

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MURSHED 39. Registrar's Signature 1126

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MD

Åg			1 - State of Maryland / Department of Health and M Certificate of Death	Mental Hygier Reg. I	21116	1711				
	Physici	an	1. Decedent's Name-(First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death				
1	/Medic Examin	al	MODIC MIJON	Hpril 8	4c. County of Death					
	LAdillii	Ç1	120 ALLENDALE STREET Baltimore		NA					
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	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
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	with the a or 28	Dire	10e. Street and Number 10f. Zip Code 120 ALLENDALE STREET 21229	10g. (Citizen of What Cou	untry?				
	oma 23	Funeral Director	I20 ALLENDALE STREET 21229	ecity Yes or No-	14. Race - Amer Black, White					
36	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or ttems 23a or 28a-f show int, Itte Madical Examinar must be notified at			, , , , , , , , , , , , , , , , , , , ,		ACK				
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more	Pages 1 ent of H nt: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		Location - City or T	own, State				
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	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funaral Director: Atter this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cause red at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)				
	Tot Tot com	Σ	29b. Signature and title of certifier D 1550	3 299	Date signed (Month	Day, Year)				
	5		30. Name and address of person who completed cause of death-(Hern 23a) (Type Print) Delth 1	18/1	Boltz	mi				
	Sta Registr	State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature								

		For State Registrar		State of		nd / Dep	artme	nt of H	lealth and Death			06	-	45
		1. Decedent's Name (F	irst, Middle, Last)						2. Date of I	Death Day	Year	3. Time o	of Death
Physic /Med		William Kil	lian							april	11	2006	08:30	0 РМ
Exam		4a. Facility Name (If not	t institution, give	street and numb	oer)		4b. Cit	, Town, o	r Location of Dea	th	4c. (County of Deat	h	
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Funera		5. Social Security Numb		x 7. 3 M 2 □ F	Age (In yrs.		/) If Und Months	er 1 Year Days	If Under 24 Hrs Hours Min		Birth Da <i>y, Year)</i>	9. Birth Con	nplace (State untry)	or Foreign
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and		Usual Residence of Dec 10a. State 10	b. County		10c. Ci	ty, Town or I	ocation						10d. Inside C	ity Limits
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ng P	Ë	27. Manner of Death 1 Matural 5	Pending	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time Injury	of	28c. Injun Wor	y at k?	28d. Describe	e how injury	occurred		
eath. or: A	cati	2 Accident	investigation Could not be				М	1 🗆	Yes 2 □ No					
al or Att s after d il Direct d in by i	Certification:	3 Suicide 6	determined	28e. Place of building	Injury - At he , etc. (Specif	ome, farm, s fy)	treet, facto	ry, office		28f. Location City or T	(Street and own, State)	Number or Ru	ral Route Nun	nber,
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exemi	sicien: To the basi ner: On the basi and manne	is of examina	ition and/or i	nvestigatio	n, in my o	pinion, death occ	urred at the time	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause(s	s)
To th withir To th	Me	29b. Signature and title	29b. Signature and title of certifier								29d. Date	signed (Month	, Day, Year)	
, ,,,		>	(129)					DH	2509		4	113/06	ç	
1		30. Name and address	of person who co	ompleted cause	of death (Item	n 23a) (Tvna	. Print)				•	-		-
S		12070		1N2 C		2	who	-DUR	f M)				
S Regis	tate	31. Date filed (Month, D		32. Reg	istrar's Signa	ature			e number 2569 F M					

			1 - State of Maryland / State of Maryland / Registrar	Department of F Certificate of			ene 006	11746	
- 8	Physici /Medic		1. Decedent's Name (First, Middle, Last) Max Albert Keys	ser		2. Date of Death April 12		3: 22 AM M	
	Examin		4a. Facility Name (If not institution, give street and number) Kline Hospice House	4b. City, Town, o Mt. Air	r Location of Death		4c. County of Dea Frederi		
	Funeral Director	Ž.	5. Social Security Number 220–28–3130 6. Sex 7 . Age (In yrs. last to 7	oirthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 13,	^{9. Bir} 1933 Ma	thplace (State or Foreign ountry) ryLand	
	Aaryland I show	ō		wn or Location				10d. Inside City Limits 1 ☐ Yes 2 X No	
	3s or 28s-	i Direct	10e. Street and Number 2722 Wolfe Drive	10f. Zip Code 21758			og. Citizen of What C	puntry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mantal Hygiene. Important: if item 27 is marked other then "naturel, or items 23s or 28s-f show any njury or other treumette event. I'm Madical Exacid at must be notified at ances.	i by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 No No No No No No No No No No No No No		ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.	
21215-0036	d within 72 hogiene. sr then "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired Public Wo	du <i>ring</i> most of worki d)	ng 1	16b. Kind of Business/Industry City Government		
Maryland	uld be file Mental Hy, irked othe	To Be C	17. Father's Name (First, Middle, Last) Raymond Ira Keyser		18. Mother's Name	(First, Middle, M e Harley			
, Man	and 2 sho selth and I n 27 is ma er treume		Mrs. Lou Ann Keyser, wife	9b. Mailing Address (Street and 2722 Wolfe			•		
Baltimore,	Pages 1: nent of He ant: If iten ury or oth		cemei	of Disposition (Name of Lery, crematory or other place burg Crematory	e) I		Oc. Location - City or Smithsbur	Town, State g, Maryland	
Balt	permit. Departi		21. Signature of Funehal Service Licensee M00255	Keeney and 106 East	d Basford	PA Fune Frede	ral Home	21701	
	Physician /Medical Examiner	_	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	on to enter the mode of dying of the second	g, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death	
68760,	icate be executed physicien and the burial-transit	dicai Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.	e of):				П 3	
P.O. Box 6	Physician: The law requires that the death certific this certificete has been signed by the attending part director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	th 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	ivery Day Year	
rds, P	w requires that been signed b should be det	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause give	en in Part I.		acco use contribute to	o the cause of death?	
al Recc	rysician: The law requisit certificete has been director, page 2 should	Completed				24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of 2 \square No	
Vita Vita	sician certifii	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 222 No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Other	26. Place of Death	-		412	
Division of Vital Records,	ing After	Certification: To	27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) 28b	. Time of 28c. Injury World	4 □ Nursing Hor		w injury occurred	city) K/198 4059168	
Divis	ital or Attendi rs after death rail Director: A led in by the fi	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	4	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a Certifier (Check only one) 1 ☐SCertifying Physician: To the basis of examination a and manner stated.	and/or investigation, in my of	pinion, death occurre	ed at the time, dat	te and place, and due	to the cause(s)	
•	To with	~	29b. Signature and title of certifier	29c. License			d. Date signed (Mont		
Q	q		of the thought of the state of	y (Type, Printy	eds.	S/- E	112	2006	
0	Sta Registr	- 1	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Soules		1-0	ed en G	10 2174	
	Registr	ar	APR 1 4 2006	Sperke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hyglene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Pay 2006 LOUISE KELLER CATHERINE 05:20 Au 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Haltimore 4b. City, Town, or Location of Death Center OWSOR H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Days Hours Min. Aug. 12, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2**X**) F 271-09-8313 90 Ohío Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Parkville 1 Yes X No 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 2932 Summit Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: 3 □Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) At Home College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward LaFontaine Olive Mary Rumschlag 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2713 Sarah Lane-Parkville, Maryland 21234 Marianne L. Hoyt-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. John S Catholic CH. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-18-06 Hydes, Maryland 4 ☐ Donation 5 ☐ Other (Specify) CEMELERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road-Parkville, MD 21234 taolo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 □Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

The law requires that the death certificate be executed use as the burial-transit the ettending physicien and Division of Vital Records, P.O. Box 68760, s been signed by the should be detached certificate has page 2 Physicien: ours efter death.

Interest Director; After this certific filled in by the funeral director, or Attending To the Hospital o within 24 hours eff To the Funerel Di

Physician

/Medical

Examiner

Funeral

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permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any Jury or other traumatic event 2028.

Physician /Medical

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Certification: To Be

Medical

with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Registrar

BOON P LIM, M. D. 31. Date filed (Month, Day, Year) State APR 1 4 2006

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE . Registrar's Signature

and mapner stated

ORIGINAL

29c. License number

D37254

TOWSON, MARYLAND 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Year 12th 2006 Physician 1221 April nordon Kepnan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ARMEY STORIL 5. Social Security Number ARS II Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□F Months 213-07-3311 MARYLANC JAN. 24 1915 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State ?7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director BASTIMORE MALERALT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 777 21334 BRIARI KOPK 1818 2 should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or itema 236 13. Was Decedent of Hispanic Origin? (Specify Yes or No. II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIEMAKE BETHLEHER 4RS. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental BOOTH KIRNA 2 HARLES IARY I ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1818 BEIBRUTEF ROAD PENKILLE permit Pages 1 and 2 s Department of Health ar Important: if item 27 is any in ury or other trau KERDAD GORGONE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) APRIL Date 20a. Method of Disposition 15⊈ Burial 2 ☐ Cremation 3 ☐ Removal from State ONLANZY VALLEY LINA LO 4 □ Donation 5 □ Other (Specify) Timpolival Balance 2006 22. Name and Address of Facility & FLO EVANS FHAPE BEOND 8800 HARFORD ROPO 21. Si mailur of Funer Service Licensee 91937 12mgRizs PARKVILLE 1ARTHAND STOR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final umania **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Debility Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequent e of) Examine signed by the attending physicien and be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown VIron 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an irector, page 2 s autopsy 2 No 1 Yes Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital Other: 4 Distursing Home 5 Residence 6 Other (Specify) After this c Certification: To 1 ☐ Yes 2 ☐ Mo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne eath 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Al investigation 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide ō Hospital Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the h 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006 30. Name and admess of person who completed cause of death (Item 23a) (Type, Print) 6800 Walth Landema 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2006 Registrar

12:

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** EVELYN 5.32 PM Monroe 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 118 MORRIS ANN ARUNDEL court GLEN BURNIE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1□ M 2 1 F 213 - 30 - 2509 12 Vrs MD Director 05.05 1933 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r then "natural", or iteme 23a or 28a-f shor the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MO GLEN BURNIE ANN ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 118 21060 MORRIS COLLRI deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ASST. DIRECTOR OF NURSING HEALTH CARE 12 TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental ELSIE HOLIDAY JAMES HOLLOWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49 nt of Health a :: if item 27 is r or other tre AVENUE BALTO. MD BERNADETE WARDLAW 5509 ALBAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: if any injury o 04-13.06 ARBUTUS BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Funeral Service Licens Vaughn 5151 BALTO, NATE PIKE, BALTO, MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** unrediali /Medical Due to (or as a consequence of) Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cons uence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s autopsy performed Onic 1 Yes 2 No 1 TYes 2 \(\text{No} or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: / 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funerei Di completely filled in To the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REDDY 7845 OAK DR ShoBhA D. 31. Date filed (Month, Day, Year) D. 2. Registrar's Signature State APR 1 4 2006 Sel. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2006 019 9 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5 MOVE thinest 10 win OY au 0 8. Date of Birth (Month, Day, Year) Nov.8, 1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Social Security Number 6. Sex Min. Days Hours 1 □ M 2 🗓 F 216-03-1338 Director 94 Nov.8, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21228 USA 303 Gralan Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental John Pleasant Anna Rappold ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl ment of Health an ant: If item 27 ls r 303 Gralan Road; Catonsville, Maryland 21228 Robert M. Milanicz Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation | 5 ☐ Other (Specify) Crest Lawn Mem. Garden 4/15/2006 Marriottsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Lice (see Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mosocomia Days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner S. uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects. b. Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ØUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autoosy perform 1 Yes Hospital or Attanding Physician: pacute Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 ZNatural 2 ☐ Accident 5 Pending investigation 2 🗌 No death. 1 Tyes after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a To the Funaral L filled 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 6291 2006 10 + OSPITALIS ompleted cause of death (Rem 23a) (Type, Print)

State Registrar

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32. Registrar's Signature

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	Ė	Funeral		5. Social Security Number 218–26–2054	6. Sex	7. Age (In yrs. 91	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Bir (Month, Da July 2	th v, Year)	9. Birthr	place (State or	Foreign
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Registrar

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06-02288 Please Type or Print in Black Indelible Ink Morrisey, Anthony State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 2, 2006 6:31PM Morrissey Medical Examiner Anthony Ten Eyck 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Fort Washington, MD Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 412-64-5802 1 XM 2 F JAN 11 1940 TN 66 Usual Residence of Decedent É 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygene and I fleath and Mental Hygene and I fleath 27 is marked other than "natural", or items 23a or 28a-f show are 1f then 27 hours of the Medical Examiner pust be notified at once. 1 X Yes 2 No N/A N/A Washington, D.C. Director 10g. Citizen of What Country? 10e. Street and Number 1701 16th Street, N.W., #134 Marital Status 12. Was Decedent Ever in U.S. USA 20009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Married 1 Yes 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: white 3 Widowed Specify: or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) Baltimore, MD 21215-0036 5+ Microbiology Microbiologist 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Morrissey Frances Brown Evck Ten 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) P.O. Box 18, George's Mill, NH Amanda M. Slack - daughter 20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 4/7/2006 crematory or other place) Beltsville, MD Chesapeake Crematory Donation 5 Other Specify. 22 Name and Address of Fac CAFA, Steph 8717 Green phen D. Lohrmann, PA ²¹²⁸⁶ h Pastures Drive, Towson, MD M00986 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** /Medical a Hypoglycemia complicating hypertensive atherosclerotic cardiovascular dise Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical TX AMENDED item#1,23a,27,perME,g854,4/27/06 TT X UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 1 Live birth 3 Ectopic pregnancy 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L. ģ 1 Yes 2 No 3 Probably 4 V Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?
1 ✓ Yes 2 No death? 26. Place of Death (Check only one) 25. Was case referred to medical Other: Nursing Home 5 Residence 6 Other Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 ☐ DOA 1 V Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 3, 2006 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Registrar

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Fune Direct		5. Social Security Number 213-21-9266	•	Age (In yrs. 96	last birthday) Yrs.		er 1 Year s Days	If Under 24 Hours	Min. 8.	Date of Bir (Month, Da Pt 3	i th Y 1 2909	9. Birthp Coul	place (State o	or Foreign Jary
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Baltimore, permit. Pages 1 ar Depertment of Hea mportant: if item any injury or othe		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.			Place of Disponentery, crei				Date / 17/06	5		on - City or To	own, State	
Balt permit. Depertr importe	OUCE:	21. Signature of Funeral Service L	Ory		R	uck	Towso	s of Facility n Fune			Tow	O York Ison, M)4
Physicia /Medic Examin	al	23a. Part1. Enter the disease, or shock, or heart lailure. List of Immediate Cause (Final disease or condition resulting in death)	END S		DEMENT		ode ol dying	, such as ca	ardiac or res	spiratory a	rrest,		Approximate Interval Bett Onset and I	ween
Box 68760, sath certificate be executed ettending physicien and for use as the burial-transit	cal Examiner	Sequentially list conditions, in y leading to in neclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a consequ										
I Records, P.O. Box 68760, The law requires that the death certificate be executed attents been signed by the ettending physicien and aga 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 Fetal	death 3	Ectopic Other (pregnancy specify)				23d.	Date of delive Month		Year
Cords, P w requires that been signed t should be deta		Part II. Other significant condition	ns contributing to death	but not resu	ulting in the u	nderlying	cause give	n in Part I.				contribute to tho		leath? Jnknown
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of Vital F Physician: Th this certificate ral diractor, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		50 /0		Othe	26. Place o					Hoop	
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Division To the Hospital or Attending within 24 hours eiter death To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could n 4 Homicide determi	28e. Place of	Injury - At ho etc. (Specify	ome, larm, str	eet, lacto	ry, office		281.	Location (S City or Tox	Street and Ni vn, State)	umber or Rura	l Route Numi	ber,
he Hospil in 24 hour he Funeri	Medical (29a. Certifier 1 Certifying (Check only one)	Physicien: To the be xaminer: On the basis and manner	of examinat	wledge, death tion and/or in	occurre vestigatio	d at the time on, in my op	e, date and p inion, death	place, and o	due to the t the time,	cause(s) and date and pla	d manner as si ce, and due to	ated. the cause(s))
To the To the Company of the Company	Σ	29b. Signature and title of certifier				2	D 47	number			29d. Date sig	gned (Month,	Day, Year)	
3		30. Name and address of person v	men serveren ber		artista (Martin			WOUTH	N M	2100	'/			
	State strar	31. Date filed (Month, Day, Year) APR 1 4	2006 2300 D	strar's Sign	ture	N. S. S. S. S. S. S. S. S. S. S. S. S. S.	1	IMONIU	m, MD	Z1U5				

DHMH 17 Rev 1/2001

APRIL 13, 2006 1:30 p.m.

MARIANNE MUNSTER

TIMOTHY MULLEN

		For	State of Marylar	nd / Depa	artmei	nt of Hea	th and M	•		egible.	1 4 4000	gun a jan
		1 - State Registrar		Cei	rtifica	te of Dea	ath		Reg. No.	1116_		56
Physic /Med		1. Decedent's Name (First, Middle, Last) Timothy Patrick Mu			1				12, Day	2006 Year	3. Time of 9:35	P M
Exami	ner	4a. Facility Name (If not institution, give s Stella Maris Hospi				Town, or Loca nium	ation of Death			ounty of Death timore		
Funeral Director		22. 00 /0/2	7. Age (In yrs.	last birthday) Yrs.	If Unde Months		Inder 24 Hrs. ours Min.	8. Date of Bird (Month, Da Aug. 3	Year 19	9. Birthi Cou	olace (State o	r Foreign
Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State MD Baltimore		ty, Town or Lo	ocation						10d. Inside Cit	•
with the	i Director	10e. Street and Number 1812 Aberdeen Road		,		Code 234			10g. Citizer	of What Cou	ntry?	
ire, INIALYICATIO A LA ID-UUSO 1 end 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notitled at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I.S. 13.	Was Dece If Yes, spe 1 Yes		ic Origin? (Spaxican, Puerto	pecify Yes or No Rican, etc.)	14.	Race - Ameri Black, White, pecify:		
Maryiaria 414.15-0050 d 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other then "naturel", or treumatic event, the Medical Exem	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give	kind of wi DO NOT i	ial Occupation ork done during ise retired)		_		of Business/In		
filed w Hygier ther th	S	12		Distri	buti	on Cent				ness Fo	rms	
Viand build be fi Mental H arked otl	To Be	James T. Mullen				1		e (First, Middle, Bencive		mame)		
Te, Maryla 1 end 2 should Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty) Michael Mullen	pe, Print) / SON		51	s (Street and N tez Dri		ral Route Numbe	r, City or To		Code)	
altimore, mit. Peges 1 er pertment of Hea portent: if Item y Injury or other		20a. Method of Disposition 1 ☑NBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation /5 ☐ Other (Specify)	amoust from State	Place of Dispo cemetery, crer	sition (Na	me of	1	Date		ion - City or To		
Baltimor permit. Peges Depertment of Important: If it any injury or o		21. Signature of Funeral Service Dicense		22	2. Name a	nd Address of	Facility		1050	York	Road	
0 0 7 4 0		23a. Part1. Enter the disease, or compli	cations that caused the deal			OWSON F				son, MD	21204 Approximate	
Physician ate be executed which is a property of the price of the pric	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):	NDIX							
T.C. BOX 60/10 het the death certificate b d by the ettending physic leteched for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	il death 3	Ectopic p				23d	Date of delive		/ear
	ď	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying	cause given in I	Part I.			contribute to the		
UNISION OF VICE THE COLOS, P.O. I or Attending Physicien: The law requires that the effer death. Director: After this certificate has been signed by the funeral director, page 2 should be detected.	Completed							24a. Was autop perfor	med?	4b. Were auto prior to co death? 1 ☐ Yes	psy findings amptetion of ca	available ause of
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or Atlanding Physician: The lay or Atlanding Physician: The lay lifer death. Director: After this cartificate has in by the funeral director, page 2	tion; To	27. Manner of Death 1 ▼Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		OA Other: 4 28c. Injury at Work? 1 □ Yes		ome 5 Resid) HOSP	ICE
= 2 ft = =	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str (y)				28f. Location (S City or Tow	Street and N m, State)	lumber or Rura	l Route Numb	ber,
L To the Hospitel within 24 hours e To the Funerel I completely filled	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my known of the basis of examination and manner stated.	owledge, death	occurred vestigation	at the time, da	te and place, , death occur	and due to the ored at the time, or	ause(s) and date and pla	d manner as s ace, and due to	ated. the cause(s))
To the within 2 To the complet	Me	29b. Signature and title of certifier			29	c. License num				igned (Month,	Day, Year)	
		30. Name and address of person who co	moleted cause of death /ltos	n 23a) /Tunn	Print	D 437	25		4/1	3/06		
10		DR. TARIQ MAHMOO	D 2300 DULAN	EY VAL	LEY I	D. TI	MONIUM	MD 2109	93			
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 4 2006	2. Registrar's Signa	ture for	de la							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 2006 DONALD JOHN NEWMAN, SR. **Physician** 5 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Wads Burnit Anni Trans 5 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 21, 19 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1**X**□M 2□F 213-32-9842 Director 70 1935 Maryland Usual Residence of Decedent the Maryland 10d. fnside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1513 Cypress Street 21226 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 [X]No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 M Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder Private Sector 0 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Newman Mary Zang ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mark Newman (Son) 1513 Cypress St., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory, INC. 4/15/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility 21225-1856 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, hearing to minimizate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, page 2 should be bes 1 Yes 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 2 No certificate 1 ☐ Yes Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA this After the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō within 24 hours a
To the Funeral I
completely filled 29a. Certifier 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) title of certifier 29b. Signature an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) :0V2)7 70

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 4 2006

ewinan

32. Registrar's Signature

19:07

1 X Yes 2 No

Approximate Interval

Between Onset and

Death

2 No

28f. Location (Street and Number or Rural Route Number, City

or Town, State)
E. Randolph/ Tournaline Ct., Silver Spring, Md.

April 9, 2006

29d Date signed (Month, Day, Year)

Division of Vital

Hospital or Attending Physician: 24 hours after death. After

2 🗸 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifie

State Registrar

Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) APR 1 4 2006

30. Name and address of person who completed cause of death (Item 23a)

and manner stated.

Could not be

(Specify) Local Street

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 10/2003

		4	1 - For State Registrar	State	of Marylar	-			lealth a			Reg. No.)06	Market of the State of the Stat	1759	
	Physicia	an	Decedent's Name (First, Middle	, Last)		Manue					2. Date of De Month	Day	Yea		3. Time of Death 438 PM	
	/Medic		Julianne			Nguy		T	1	(D	April	2	ZOO County of Di		430 PM	
	Examin	er	4a. Facility Name (If not institution Johns Hopkins Hos)	•	umber)		Balti		Location of	of Death			ltimore	eatri		
-			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		1 Year	If Under	24 Hrs.	8. Date of Bir	th		Birthpla	ce (State or Foreigi	n
	Funeral Director		213-65-8846	1 □ M 2 X □ F	3	Yrs.	Months	Days	Hours	Min.	(Month, Da August 27		- 1 .	Country lary]		
	0	ļ	Usual Residence of Decedent							1	9000 =	,				_
	how	-	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							100	d. Inside City Limits 1 Yes 2 No	
	Ba-f	ecto	Maryland Prince	George	Laur	el	101.7	0-4-				10- 00		Courte		
	Mora Lean	듬	10e. Street and Number				10f. Zij						en of What	Countr	y r	
	eath	Funeral Director	14306 Wicklow Lane	12. Was De	cedent Ever in L	J.S. 13. 1	207 Was Dece		ispanic Ori	igin? (Spe		U.S.A	4. Race - A	merical	n Indian,	
	riter d	Fun	1⊠ Never Married 2 Marr	Armed F ied 1 ☐ Yes	orces? 2 🔀 No						cify Yes or No Rican, etc.)		Black, W			
Š	er', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	live Dates:		1 ∐ Yes	2KJ No	Specify:				Specify: F	star		
5	72 hc	Completed	15. Decedent (Specify onfy highes	's Education	()	16a. Dece	dent's Usu kind of wo	al Occup	ation during mos 1)	t of workii	ng	16b. Ki	nd of Busine	ss/Indu	stry	
7	han.	mpl	Elementary/Secondary (0-12)	College	(1-4or 5+)			se retired	1)							
V	filed within 72 hours after death with the Maryland Hygiene, the Hydiene, or Items 23s or 28s-f show the then "naturel", or Items 23s or 28s-f show ant, the Medical Examil at Items Le notified at	ပိ	17. Father's Name (First, Middle,	(ast)	0	None			18. Mothe	er's Name	(First, Middle	No. Maiden				
=	d be t	o Be	Binh Thai Nguyen	,						lauyen						
	should and Men marke umatic	은	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Addres	(Street			l Route Numb	er, City o	Town, State	в, <i>Zip С</i>	code)	_
ž	1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Binh Thai Nguyen,	/Father		14306	Wick	ow La	ne Lau	rel.	Maryland	2070	7			
ָ בֿע	mit. Pages 1 an bartment of Heal cortant: if item 2 / injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Pomoval from	1	Place of Dispo cemetery, crea	sition (Na	me of			ate		cation - City	or Tow	n, State	
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F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Card		Aco	<u>est</u>						_ 1,	2 hours	
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00/00	ate b	dical		d.										1		
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<u> </u>	requires that the de een signed by the e nould be detached f	by PI	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlyin g	cause giv	en in Part I	l.	23e. Did 1	tobacco u	se contribut	e to the	cause of death?	
cords	w require been sig should b										10	Yes 2	No 3□	Proba	bly 4 □Unknowr	1
000	aw 2 st 2 st	plet									24a. Was		24b. Were	autop:	sy findings available	а
ř	ate pag	Completed									perfo 1 ☐ Yes	ormed? 2 🗖 No	death 1 🗆 \	1? fes 2	. ☑ No	
IIa	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Handal				Oth			(Check only					
6	Phys this aldii	ို	1 Yes 2 No 27. Manner of Death	1	Inpatient 2	28b. Time o					ne 5 Resi			Specify)		
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			30. Name and address of person			m 23a) (Type,	Print)	16-	CI	7	Himor	0	MD	21	287	
					Registrar's Sign		, W	ite	57.	Da	H, MOC	<u> </u>	· •	41	607	
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			State Registrar			Cer	tificat	e of L	Jeath		2. Date of De	Reg. No.	100	3 Time	of Death
	Physicia /Medic		1. Decedent's Name (First, Middle, Las MADELINE W. PORTER								APRIL	Day 12	2006	11	:05P ^M
	Examin		4a. Fecility Name (If not institution, give	street and numbe	r)				Location of	of Death			ounty of Dea	ith	
H			LORIEN OF BELAIR 5. Social Security Number 6. Se	y 7	ane (In vrs	last birthday)	If Under	LAIR 1 Year	If Under	24 Hrs.	8. Date of Bir		RFORD 9. Bir	rthplace (Stat	e or Foreign
	Funeral Director			TH MINE	4	Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da Jan. 2	8,192	C	arylanc	
	and iand		10a. State 10b. County		10c. Cit	y, To wn or Lo	cation		-					101	City Limits
:	Mary	to	Maryland Harford	d		Belair								1 🗆 Y	es 2 No
;	or 284	Director	10e. Street and Number				10f. Zip						n of What C	ountry?	
	23a	la	1909 Emmorton Rd.	Apt. 11				1015				US.		erican Indian	
9	be filed within 72 hours after death with the Maryland and Hygiene. And they than "natural", or iteme 23a or 28a-f ehow do other than "natural", or iteme 23a or 28a-f ehow evant, the Medical Examinar must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decede Armed Force 1 ∐Yes XX If Yes, Give	s?		was Dece If Yes, spe 1 Yes		n, Mexicar Specity:		ecify Yes or No Rican, etc.)		Black, Whi	ite, etc.	,
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Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Marylan and Mental Hygiene. Indexted other than "natural", or items 23a or 28a-f show imarked other than "addical Examinar must be notified at	To Be C	17. Father's Name (First, Middle, Last) Robert Hellman								e (First, Middle oblitt	a, Maiden S	umame)		
lary	permit Pages 1 and 2 should be Department of Health and Mental important: if item 27 is marked any injury or other traumatic events.	-	19a. Informant's Name/Relationship (1					a <i>l Route Numt</i> lston,			Zip Code) 21047	
e)	1 and Health Am 27 ther t		Wayne M. Porter (20a. Method of Disposition	3011)	20b. F	Place of Disponentery, crei					Date			r Town, State	
no.	ages int of t: ff it		XXXBurial 2 Cremation 3 4 Donation 5 Other (Specify			remetery, crei				~18~2	2006	Balt	imore,	, Md.	
Ħ	artme cortan injur		21. Signature of Funeral Service Licer				assai	-		† H∩r	me				
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	Physician		23a. Part1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause on each	sed the deat 1 line.	th. Do not en	ter the mo	de of dyin	g, such as	cardiac	or respiratory a	arrest,			mate Between nd Death
	/Medical Examiner		resulting in death)	Due to (or	as a consec	quence of):								2).	1
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	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events causing in death).	c Tu	lmo	William.	1	بناط	داً ک					42	7
o,	te be executed ysicien and e burial-transli		resulting in death) Last	Due to (or	as a consec	quence of):								0	
8760,	cate b	dlcal		d											
Box 68	eath certificate be executed attending physicien and for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregn	ancy	∃Ectopic r	recessor.				2:	3d. Date of d	-	
.O. B	it the death by the atte tached for	Physiclan/Medl	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4☐Pregnan 9☐Unknow	t at time of o		Other (s						Month	Day	Year
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tal	ician: Th certificate rector, pag	O	25. Was case referred to medical						26. Plac	e of Dea	th (Check only				
<u> </u>	Physici this cer ral direc	To B	examiner? 1 □ Yes 2 🛣 No	Hospital: 1 🗆 Inp	atient 2] ER/Outpatie	nt 3 🗆 🗅	OA Oth	ier: 4反N	ursing H	ome 5 Re			oecify)	
	ing Afte une		27. Manner of Death 1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury Day Year)	28b. Time of Injury	of M	28c. Injur Wor 1 □	yat rk? Yes 2.⊑]No	28d. Describe	how injury	occurred		
Division	deat deat stor: / the	Certification:	2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At h	nome, farm, si ify)					28f. Location City or T	(Street and own, State)	Number or	Rural Route I	Number,
۵	To the Hospitel or A within 24 hours after To the Funeral Direc completely filled in by		29a. Conflict 1X Contifying Pl (Check only 2 Medical Exa	hysician: To the b miner: On the bas	est of my kn	cwlodge, doa ation and/or in	th opnuma	d at the til	me, date a	nd place	and due to the	e cause(s) e, date and	and manner place, and d	as stated lue to the cau	se(s)
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	Wit.	1	SThose	W.D.				D2	654	5		4	14/0	56	
	7		30. Name and address of person who SHILPI KHOSLA 31. Date filed (Month, Day, Year) APR 1 4	completed cause	of death (Ite	em 23a) (Type	, Print)		BEL	AIR	2 M	D 2	1014	.	
Y) ·	ate	31. Date filed (Month, Day, Year)	32. R	istrar's Sign	nature	1		_						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deat Month **Physician** 1:10 PM ear /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Carroll 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
April 27,1926 Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🕮 F Yrs. 79 Director 217-26-6481 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examination of the rediffical at once. 10a. State 10b. County 1 ☐ Yes 2 🔽 No Maryland Carroll Westminster Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3516 Oxwed Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: USA ð 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) C & P Telephone Company Telephone Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frances Ambrose Leroy Hamlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 207 Blakeney Road; Catonsville, Maryland 21228 Shawn P. Rink - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4/13/2006 Loudon Park Cemetery Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Servi 21. Signal Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville MD 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1, Ente Immediate Cause (Final disease or condition resulting in death) Physician Gravaga /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 3 Probably 4 Unknown as been signal 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy r this certificate has performed' 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25 or Attending Physiclen: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ₩0 1 Inpatient After this c ို 2 ER/Outpatient 3 DOA 27. Magner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1) Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 📂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 MO completed cause of death (Item 23a) (Type, Print) 30 Name and address of person who 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#7, per FH 2854 (20/06 TT Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2006 **Physician** Harry Rode April 10, 1:10 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Fallston 3101 Winchester Way | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 1 M 2 □ F Poland Yrs 71 Director 440-36-5045 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show other traumatic event, the Medical Examiner must be nutilised at 1 ☐ Yes 2 No Fallston Harford Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21047 U.S.A. 3101 Winchester Way or items 23a death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be lifed within 72 hours after and of Health and Mental Hygiene. 1 Never Married 2 Married 1⊠Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ If Yes, Give Year or Dates: Specify: white 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) other than gas and electric co. station service manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugenia Pahl Paul Rode f Health and Menta Item 27 is marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3101 Winchester Way, Fallston, Md. 21047 Lillie Rode/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/15/06 Fallston, Md. Highview Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Parkinsons Discase Physician years /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Uisease or injury] Completed by Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. as the the attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year should be detached for in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 III Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 2 1 No 1 Yes Division of Vital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28c. Injury at Work? the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined 4 Homicide To the Hospitel 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 51185 s of person who completed cause of death (Item 23a) (Type, Print) 5505 top kins Bay view Circle. Pollzen Christmas, MD Bultimore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

			State of Maryland / Department	artment of Health and Me rtificate of Death	ental Hygien	0000 11760
1	Physici	-	1. Decedent's Name (First, Middle, Last) Richard Arlen Reed		2. Date of Death	3. Time of Death 8:50 AM
Ī	/Medic Examin	_	4a. Pacility Name (If not institution, give street and nymber).	4b. City, Town, or Location of Death	-	4c. County of Death HARRY
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 230-54-7054 1 M 2 F 69 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Feb. 13, 1	9. Birthplace (State or Foreign Country) 1937 Virginia
	pu *		Usual Residence of Decedent 10c. City, Town or L. 10a. State 10b. County 10c. City, Town or L.			10d. Inside City Limits
	Maryis -f aho	tor		avre de Grace		1 ⊠ Yes 2 ☐ No
	h with the 3a or 28a	al Director	10e. Street and Number 127 N. Stokes Street	10f. Zip Code 21078	10g. C	Citizen of What Country? U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any injury or other traumatte event, Ite Madical Exabit at most be notified at once.	by Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ₺ No	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 🌠 No Specify:	offy Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
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Maryland 2	d be filed v ental Hygie sed other t c event, IL	Be	8 years 17. Father's Name (First, Middle, Last) James C. Reed	18. Mother's Name	(First, Middle, Maide	ən Sumamə)
ary	should and Me s mark umation	2	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural	Route Number, City	
Σ ()	and 2 lealth a m 27 i		RE 1000101 11000/ 1100	Meadowood Court, I		Md. 21040 Location - City or Town, State
nore	ages 1 ant of H it: If ite y or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	matory or other place) Crematory 4/14		ltimore, Md.
Baltimore,	permit. F Departme Importan any injur		21. Signature of Eugeral Service Licensee	2. Name and Address of Facility Schimunek Funeral I	Home of Be	el Air, Inc.
	A		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	610 W. MacPhail Ros ter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
*	Physician		Immediate Cause (Final disease or condition resulting in death)	ic Lyna C	ancev	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
	D H	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c			
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x 68	n certifica anding ph use as th	Med	IF FEMALE:			
Q	death	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	es that the igned by th be detache	by Pi	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		to use contribute to the cause of death?
ord	tw requires that s been signed b s should be det	eted	Acquired Immunodeticil	ncy Syndrome	1 Tyes	
Vital Records,		Completed			24a. Was an autopsy performed?	
/ital	cian: ' ertifica ector, p	Be C	25. Was case referred to medical examiner?	26. Place of Death		10 100 1010
	Physician: r this certific ral director,	. To	1		ne 5 Residence	6 ☐Other (Specify)
ion	Attending in death.	atior	t	Work? M 1 ☐ Yes 2 ☐ No		
-	al or Attendi s after death al Director: A ed in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 2	8f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
	To the comple	≥	29b. Signature and title of certifier	29c. License number	29d. 0	Date signed (Month, Day, Year)
h	d		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 19583	OA	pril 14,2006
17) .		Manuel M. Lazarth M	P & Law	IT ziet	/ Aberd sery
12.2	Sta Regist		31. Date filed (Month Argy RY ear) 4 2006 32. Hegistrar's Signature	part /		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Physician WAYNE ALLEN RIECKE 10, 8:54 PM APRIL 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 5210 WHITE PINE DR. CARROLL HAMPSTEAD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1⊠M 2□F 42 Yrs. 219-82-4788 Director 10/10/1963 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If the theme 23a or 28e-f show then treumstic event, the Medical Exament to make the colling a 1 ☐ Yes 2√ No Director HAMPSTEAD CARROLL MD 10e Street and Number 10g, Citizen of What Country? 10f. Zip Code USA 21074 5210 WHITE PINE DR. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. à Specify: WHITE 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION IRON WORKER & WELDER 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DICUS MARILYN EUGENE HAROLD RIECKE မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5210 WHITE PINE DR., HAMPSTEAD, MD 21074 EUGENE H. RIECKE - FATHER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite eny Injury or ot 1 Durial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN MEM.PARK 4/14/2006 GLEN BURNIE, MD -4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLETCHER FUNERAL HOME Funer | Service Licensee Signatur 254 E. MAIN ST., WESTMINSTER, MD 21157 Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Monoxide Poisoning **Physician** minutes rhon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transit be executed Due to (or as a consequence of). Box 68760. attending physicien for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be deteched o 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 25 No certificate 1 Yes Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1XYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 27. Manner of Death Inhaled vehicle exhaust To the Hospitel or Attending within 24 hours after deeth.
To the Funerel Director: Aft 1 Natural 5 Pending 2043 M 4/10/06 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Dr. City or Town, State) 5210 White Pine Dr. 4 Homicide AT HOME HAMPSTEAD, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signatuce and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) DO051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5r.mn 2973 Manchyster Rd Manchester Herbert P. Henderson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR. 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registra Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) **Physician** /Medical street and number) (If no Anstitution or Location of Death Examiner rs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Min. Director with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or Itams 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Inside City Limits 1 ☐ Yes 2 ☐ NO by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White etc. 11. Marital Status 1 Yes 2 DNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: 3 Nidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education sify only highest grade completed) 16b. Kind of Business/Industry during most of working ndary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Last) Be ship (Type Address (Street and Number of lace of Disposition (Name of 20a. Method of Displ sition 1 Burial 3 Removal from State 5 Cher (Specify) uneral Service License .21. Signature of Address of Facility 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the more of Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of):

Deacc Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): this certiticate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 1 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certilica completely tilled in by the tuneral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Nesidence 6 □Other (Specify) 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Till Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 68 13 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **APR 1 4** Registrar 2006

		-	1 - For Amend Item#20b	State of Ma per FH G	ryland 854	4/Pepi 4/Pepi	artmei rtifica	at of H	ealth ar Death	nd Me	ntal Hy	giene Reg. No.	006	1176	6
Db.			1. Decedent's Name (First, Middle, Last)								Date of De.			3. Time of Death	
	sicia ledic		Vivian Augusta ¹	Reese							April	12			٢M
Exa	amine	er	4a. Facility Name (If not institution, give st. Sinai Ho.	spital			1	2/4	Location of I	Ci	ty		County of Death		
Fune Direc			213-00-1404	7. Age	(In yrs. la	ast birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Min.	. Date of Bird (Month, Da 1ne 1	y, Year)	9. Birth Co.	nplace (State or Fore untry) yland	sign
land	=		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Lim	nits
Mary	2	to	Maryland N/A		В	altir	nore							XXYes 2□	No
h the		irec	10e. Street and Number			<u>arcii</u>		p Code				10g. Citi	zen of What Co	untry?	
I K I 3-UU30 within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show	5	Funeral Director	3012 Thorndale	Avenue A	Apt.	2		2121	5			US.	A		
r dee		ner	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U.S	S. 13.	Was Dece	edent of Hi ecity Cuba	spanic Origir n, Mexican, I	n? (Speci Puerto Ric	fy Yes or No can, etc.)	-	 Race - Amer Black, White 		
s afte	ame.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑N	D		1 🗆 Yes	2 ∑ No	Specify:				Specify: B1	ack	
hours a	2		15. Decedent's Educa	Year or Dates:		16a. Dece	dent's Us	ual Occupa	ation			16b. Ki	nd of Business/l	ndustry	
1 7 m	No.	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed)		(Give	kind of w	ork done d use retired	turina most o	of working					
d with	9	Completed	11th grade	College (1-4or 5-	-7	Res	iden	tial	Coun	sel	or	PLI	vale I	ndustry	
d be file	Vent	Bec	17. Father's Name (First, Middle, Last)	D							First, Middle, Mae				
lary latter ZTZ 13-0030 2 should be filed within 72 hours after deeth with the Marylan and Mental Hygiene. Is marked other than "natural", or liems 23e or 28e-1 show	atics	Lo	Peter Augustus	Keese											
2 sho	or other traumatic	1	19a. Informant's Name/Relationship (Type										r Town, State, Z imore	ip Code) Md 2121	5
t and theelth			Dorothy M. Rees 20a. Method of Disposition	e/Motne	The later which the	ace of Dispe			15011				cation - City or		
Daltimore, permit. Pages 1 an Department of Heel Important: If Item 2	6		1 ☐ Burial 2X Cremation 3 ☐ Re	moval from State	ce	emetery, cre	matory or	other plac	etery	/15*				Marylan	Ē
Dartimo	der.		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice see		Gre						700			neral H	
	Suy E		21: Signature of the state of t	,										Md 2121	
-		4	23a. Part1. Enter the disease, or complic	ations that caused	the death								Ī	Approximate	
Dhysia	ion	_	Shock, or heart failure. List only one Immediate Cause (Final			1	. /	A	-					Interval Between Onset and Death	
Physic /Medi			disease or condition resulting in death)	Due to (or as a	consequ	ence of):	rtery	. 0	156456	e					
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ם פ	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	CONSTRUCT	ience of).	, ,	_							
and	trans	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a	sest	w !	fecont	14	lune						
cate be executed physicien and	ouria			Due to (or as a	A-H	ence or).									
OX OG / OU, certificate be executed nding physicien and	s the	dical	d.		, , , ,	ma									
BOX B leath certific ettending p	150 25	/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome o	of pregnar	ncy							23d. Date of deli	verv	
a da ja	101	ciar	in the past 12 months?	1 Live birth 2 4 Pregnant at			□Ectopic □ Other (s	pregnancy pecify)					Month	Day Year	
) \$ £	ached	Physician/M	9 Unknown	9□ Unknown											1.0
ords, F.O. requires that the de	e det	by P	Part II. Other significant conditions cont	nbuting to death bu	t not resu	ulting in the u	ınderlying	cause give	en in Part I.		23e. Did t	obacco u	ise contribute to	the cause of death?	,
COTOS w require been sig	Din l				-						10	Yes 2	□No 3□Pr	obably 4 🗷 Inkno)WN
S a C	N I	plet									24a. Was		24b. Were au	topsy findings availa	ible of
_ t age	g	Completed									perfo	rmed? 2 No	doath?		
VITAI P sician: Th certificate	rector,	Be	25. Was case referred to medical examiner?					100		of Death (Check only o	опе)			
this	o a	2	I Tes ZENO	ospital: 1 ☐ Inpatier		ER/Outpatie 28b. Time o			4 LI Nuis		d. Describe		6 Other (Spec	cify)	
	eun	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year)	Injury	M.	28c. Injun Worl	/at ∢? Yes 2∐No		d. Describe	now injur	y occurred		
or:	the	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At ho	me, farm, st								ıral Route Number,	
र विश्व	d in by	erti	4 Homicide determined	building, etc	. (Specify	')	,	,,			City or To	wn, State)		
Hospital 24 hours Funeral	completely filled	Medical C	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin		examinat										
To the P within 2. To the P	omple	Mec	29b. Signature and title of certifier	una mambi sta	0			9c. Licens					e signed (Monti		
⊢ ≩ ⊢	٥		16.1.1	11/		_		n A	27/-			A	pril 12	,2006	
			30. Name and address of person who con	npleted cause of de	ath (Item	23a) (Type	, Print)	UT3	10				•		
- 1				2401 W	. B	ched	erc	Ave	Bal	Hno	re, m	10 -	21215	,2006	
- 1 m	Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signat	ture									
Re	gistr	ar	APR 1 4 2006	Charlen	, Si	100	and the same								

REFER, VIVION

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PT. KNOUW

			For State Registrar	State	of Marylar			nt of H		and Me		giene Reg. No.	06	11767
	Physici		1. Decedent's Name (First, Mic	CLAY7	ON	ROSS					2. Date of Dea Month April	Dav	006 Year	3. Time of Death 11:12 P M
* 有明	/Medio Examin		4a. Facility Name (If not institut 3 Market Stre	ion, give street and n			4b. City	, Town, or	Location of		1	4c. C	county of Death	
- T	Funeral Director		5. Social Security Number 329-46-9939	6. Sex 1 ☑ M 2 ☐ F	7. Age (<i>In yrs</i> . 51	iast birthday) Yrs.		Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Da)	y, Year)	Cou	place (State or Foreign Intry) inois
	show	or	Usual Residence of Decedent 10a. State 10b. Cour			ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🖫 No
	or 28a-	Directo	Maryland Har: 10e. Street and Number	tora	A	oerdeer		p Code				10g. Citize	en of What Cou	intry?
	ath w	rail	3 Market Stre			10 10	Mar Des	21001		-:-2 (0	if . Van or No	USA	4. Race - Amer	inen Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show says figury or other traumatic event, fre Medical Evatr. Instituted a softee.	by Funeral	11. Marital Status 1 □ Never Married 2X M 3 □ Widowed 4 □ Divorce	arried Armed I	icedent Ever in U Forces? s 2 □ No Bive Dates:		If Yes, sp	ecify Cuba	Specify:	i, Puerto R	ify Yes or No- ican, etc.)		Black, White Specify:	
21215-0036	vithin 72 hc ne. han "natur s Medical	Completed			(1-4or 5+)	life.	kind of w DO NOT	ork done a use retired,	luring most	t of working	9		d of Business/li	
d 21	filed w Hygiel ther ti		17. Father's Name (First, Midd.	le, Last)		Mil	Litar	У	18. Mothe	r's Name	First, Middle,		Goven	nment
lan	lid be lental ked o	To Be	Cleo Clayton	Ross					Jovo	ce C	arol F	wick		
Maryland	nd 2 shou lith and M 27 is mai r traumai		19a. Informant's Name/Relation			1	-		and Numbe	or Rural	Route Numbe	er, City or	Town, State, Zi nd 2100:	
Baltimore,	of Head		20a. Method of Disposition 1 □ Apurial 2 □ Cremation	n 3 ⊠Removal from		Place of Dispo cemetery, crea				Da		20c. Loca	ation - City or T	own, State
Ĭ	t. Pag tment rtent: I		4 ☐Donation 5 ☐ Other	(Specify)	Wil	llwood				-			ord, I	llinois
Bal	Department Department		21. Signature at Funeral Servi	Ca Incensee	D 104 - 2	N N	AcCon	as Fu	inera]	I Hom	e, P.A	adon	Marril:	and 21009
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, shock, or heart fattere. Limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Sq u	t caused the deal each line. Camcus o (or as a consector)	cell (quence of):							kidney	Approximate Interval Between Onset and Death
8760,	icate be executed physicien and s the burial-transit	licai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec	quence of):				· ·				
P.O. Box 68	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	outcome of pregn a birth 2 Feta gnant at time of a known	aldeath 3[⊒Ectopic ⊒ Other (:	oregnancy specify)				23	3d. Date of deliving Month	very Day Year
	quires that the n signed by the ald be detache	ρ	Part II. Other significant cond Renal Part		death but not re	sulting in the u	ınderlying	cause give	en in Part I.					the cause of death?
of Vital Records,	The law requires sete hes been sign page 2 should be	Completed	Renal fai Hyper calc	emia							24a. Was autop perio 1 Yes	rmed?	24b. Were aut prior to codeath?	copsy findings available completion of cause of
/ital	iclen: T certificat actor, pa	Be C	25. Was case referred to med examiner?							of Death	(Check only o			
on of V	ing Phys After this uneral did	itlon: To	1 ☐ Yes 2 🔀 No 27. Manner of Death 1 🖼 Natural 5 ☐ Pen 2 ☐ Accident inve	28a. Da	Inpatient 2 te of Injury onth, Day Year)	28b. Time of Injury		28c. Injun Worl	4 🗆 140	21	e 5 🔀 Resid 8d. Describe !		Other (Spec	ufy)
Division	F 0 F C	Certification:	3 Suicide 6 □ Cou	ald not be 28e. Pla but	ce of Injury - At I Iding, etc. (Speci	nome, farm, st	reet, facto	ery, office		2	8f. Location (S City or Tox		Number or Ru	ral Route Number,
	To the Hospital or At within 24 hours after or To the Funerel Direct completely filled in by	edical (ying Physician: To t cal Examiner: On the and m										
)	To the within To the comp	2	29b. Signature and title of cert	fier yarla	gaddy	4	2	9c. License	9 number 59 C	27	L	29d. Date	signed (Month	n, Day, Year) G
il	117		30. Name and address of pers	agadda, M	D Uncol	om 23a) (Type	Print)	Baltin	nove V	AMC,	10 N	Gree 2-1	ene St	Baltimore
	St Regist	ate rar	31. Date filed (Month, Day, Ye APR 1 4 2	ar) 32 .006 36.00	. Registrar's Sign	atura	2							

		1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H rtificate of L	Death	Reg	one 006	11768
Physici /Medi		Decedent's Name (First, Middle, Las	。 Bloria Amad	da Requer	na		2. Date of Death Month April	10, 2006 Year	3. Time of Death 6:00 p.m. _M
Examir		4a. Facility Name (If not institution, give	street and number) Gardens Assist	ed Living	4b. City, Town, or	Location of Death Colur	nbia	4c. County of Deat	h ward
Funeral Director		5. Social Security Number 6. Se		(In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry) Bolivia
show	7.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo		VI-			10d. Inside City Limits 1 ☐ Yes 2 No
with the M a or 28a-f be rolls	Director	10e. Street and Number	York		10f. Zip Code	ew York 10012	100	g. Citizen of What Co U.S	untry?
permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show may injury or other traumatic event, the Medical Exactif or mast be routified at once.	by Funeral	110 Bleecker St. Apt 17 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1 Dyes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi. If Yes, specify Cubar 1 □ Yes 2 No	spanic Origin? (Spec n, Mexican, Puerto F Specify:	city Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:	
l within 72 ho iene. r than "natur	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+ 1	(Give	DO NOT use retired)	luring most of workin	g 16	8b. Kind of Business/ Busines	Industry SS Owner
d be filed ntal Hyg ed othal	Be	17. Father's Name (First, Middle, Last)	Darwana			18. Mother's Name		des Estrada	
2 should and Me is mark raumatic	2	19a. Informant's Name/Relationship (7	Requena Type, Print)		,		Route Number, C	City or Town, State, 2	(ip Code)
ages 1 and nt of Health it if itam 27		Mr. F. Xavier Castellani 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place	Da (14)1		w York 10012 c. Location - City or Baltime	Town, State
permit. P Departme Importan any injury		4 □ Donation 5 □ Other (Specify 21. Sighaure of Funeral Service Mon			view Cremator 2. Name and Addres Slack F	y s of Facility uneral Home.	P.A.		
Physician /Medical Examiner	16	23a. Part1. Enter the disease of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	aDe to (or as a	consequence of):	ter the mode of dying			City, MD 21043	Approximate Interval Between Onset and Death 3 Mears
cate be executed physician and the burial-transit	dical Examiner	cause. Entire Underlying Causes (Usease of Injury that initiated events resulting in death) Last	c	consequence of):					
ath certifi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past N2 months? 1 Yes 2 No	23c. If yes, outcome o 1 □Live birth 2 4 □Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
w requires that the debeen signed by the a	by	Part II. Other significant conditions co	ontributing to death but	not resulting in the u	inderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
vical necon sician: The law requ certificate has been rector, page 2 shoult	Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely illed in by the tuneral director, page	Certification; To Be	27. Magner of Death 12. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	-	28b. Time o	f 28c. Injury Work M 1 □ \	at 2	ie 5 □ Residene 8d. Describe how		aving
spital or A ours after neral Dira filled in by		4 Homicide determined 29a. Certifier Certifying Phy	building, etc.	(Specify)			City or Town,	State)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely illed in by the funeral	Medical	(Check only one) 2 Medicel Exemple one) 29b. Signature and title of certifier	and manner state	examination and/or in ed.	vestigation, in my op	pinion, death occurre	d at the time, date	and place, and due	to the cause(s)
+ 3 + ŏ		•		l.D.		D56531		April 10	, 2006
5 Sta	ate	30. Name and address of person who of Harry Li, MD 10780 H	ckory Ridge Rd	I. Columbia, N	ИD 21044				
Regist	rar	APR 1 4 2	006	JI A	well				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () ()

Certificate of Death Reg. No.

			1 - For Stata Registrar	State of Marylan		artment of F tificate of			iene) () (5 11/69
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Mary Elizabeth So					2. Date of Death Month	Day	3. Time of Death 966 9136 P M
	Examing Examinating Ex	ner	4a. Facility Name (If not institution, give st FRANKI'N SQUAM 5. Social Security Number 6. Sex 217–09–0186	= Hospila		4b. City, Town, o Rose If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 8,	Year)	f Death I i MORE 9. Birthplace (State or Foreign Country) Maryland
	D	or.	Usual Residence of Decedent 10a. State 10b. County Marry Land Dollhimore	10c. Cit	y, Town or Lo			000. 0,	1520	10d. Inside City Limits 1 □ Yes 2 ☑ No
	with the M 3a or 28a-f	I Director	Maryland Baltimore 10e. Street and Number 413 Crisfield Road	MIC	iate kt	10f. Zip Code 21220		10	Og. Citizen of WI	
980	be filed within 72 hours after death with the Maryland lal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Exerting must be notified at	by Funeral	11. Marital Status 1. 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 _ Yes _ 2 No If Yes, Give Year or Dates:			ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race	- American Indian, , White, etc. White
1215-0	within 72 hou iene. 'than "natura ine Medical E	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give	OO NOT use retired	during most of work	ing	6b. Kind of Bus Own Hor	iness/Industry
yland 2	should be filed and Mental Hygic marked other amatic event, the	To Be Co	17. Father's Name (First, Middle, Last) William Harrison M				18. Mother's Name	Lowery	laiden Sumame,)
Baltimore, Maryland 21215-0036	l and 2 Health a om 27 ts		19a. Informant's Name/Relationship (Type Frances Mairose (Da 20a. Method of Disposition 1∑Rurial 2 □ Cremation 3 □ Re	aughter)	413 C		Road, Ba	ltimore,	Maryla	
Baltim	permit. Pages: Department of H Important: If Ite any Injury or ot	<	4 Donation 5 Other (Specify)	Lak	22.	Memoria Name and Addres Bi 407 Old 1	ss of Facility CUZdZinsk	i Funera.	l Home,	ille, Maryland P.A. aryland 21221
	Physician /Medical Examiner		23a. Pany. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line. END STAGE Due to (or as a bonsequent of the control of the c	n. Do not ente	r the mode of dyin	g, such as cardiac o	or respiratory arre		Approximate Interval Between Onset and Death
68760,	lificate be executed g physicien and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	D to (or as a consequence to (Neph	io scien	- 05/5		
P.O. Box 68	The law requires that the death certifica sie has been signed by the attending ph bage 2 should be delached for use as it	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	b. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Month	
rds, P.	w requires that been signed b should be deta		Part II. Other significant conditions contr	ibuting to death but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did toba	1.0	ute to the cause of death?
Vital Records,	n: The law re icete has be r, page 2 sho	Completed						24a. Was an autopsy perform	ed? dea	ore autopsy findings available or to completion of cause of ath?] Yes 2 ☐ No
₹	Physicien: r this certifice ral director, p	9 Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:		2□ DOA Othe	26. Place of Death		7.	
ō	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of	3 DOA 28c. Injury Work	4 inursing no	me 5 Residen 28d. Describe how		
Division of	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the tuneral director, page	Certification:	TNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year) 28e. Place of Injury - At ho	Injury me, farm, stre	M 1 🗆 Y	res 2 □No			or Rural Route Number,
	urs after oral Directled in by			building, etc. (Specify				City or Town,	,	
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) Certifying Physic 2 Medical Exemine	rian: To the best of my known: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time estigation, in my op	e, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and mann e and place, and	er as stated. d due to the cause(s)
)	To the Total	Σ	29b. Signature and title of certifier)		29c. License			1.1	Month, Day, Year)
75.	Ste	••	30. Name and address of person who om Dis Debra HuTigur 31. Date filed (Month, Day, Year)	pleted cause of death (Item 5 9000 FRAU 32. Registrar's Signat	23a) (Type, F	rint) Square	06257 Dr. Bal	Timore	= Md	21237

State Registrar

APR 1 4 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2006 Month **Physician** Dena Stoner Year 12, April A M 4:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Heritage Nursing Center Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 9, 1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XXX 212-24-4740 Director 78 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show other traumatic event, the Madical Examiner must be notified at Maryland Harford Edgewood 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 D Swallow Crest Court 21040 U.S.A. or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White 3 N Widowed 4 □ Divorced neturel 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygient importent: If item 27 is marked other the eny injury or other traumatic avent 12 Window Manufacturer Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk. Effie Manerva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dena Waclawski (Granddaughter) 1912 Barry Road, Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. April 14, 2006 Baltimore, Maryland 21. Signature of Fundamental Service Cicensee Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death RONF Immediate Cause (Final disease of condition resulting in death) **Physician** 1eans /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe CINOMA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown LEBROVASCULA 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No CHRONIC OBSTRUCTIVE PULMONARY To the Hospital or Attending Physician: 25. Was case referre medical examiner? Be of Death (Check only one) Hospital: 1 | Inpatient 1 ☐ Yes 2 No ٩ 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA this 27. Mann of Death 1 atural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: d in by the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a To the Funeral I filled 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature JIMORE, MAR 31. Date filed (Month, Day, Year) State Registrar APR 1 4 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician April Helen Louise Smith 12, 2006 6:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Kingsville 12650 Lee Ben Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 10, 1923 Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🙀 F 219-20-5811 83 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f ahow 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f ahow other treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Kingsville Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12650 Lee Ben Road 21087 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Amed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: White ģ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry mentary/Secondary (0-12) College (1-4or 5+) Printing Co. 12th Grade Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary A. Melnick William H. Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (grand-Dawn Januszkiewicz 12650 Lee Ben Road, Kingsville, MD daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem'l Gard 4/15/2006 | Glen Burnie, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee any ir 9705 Belair Rd., Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (fr as a consequence of): /Medical Examiner Sequentially list conditions, Due to for as a consequence of Examiner Tary leading to immedicause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed the attending physicien and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy 2 Fetal death in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à AZZHEIMER'S Denentia 1 ☐ Yes 28 No 3 ☐ Probably 4 ☐ Unknown Completed multi intront 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 2 Accident 5 Pending 1 Tyes 2 □ No investigation within 24 hours after deatl
To the Funeral Director:
completely filled in by the filled in by the 6 Could not be determined 3 🗀 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nausu(s) and manner as state-2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belgin RD 1602 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2006 Registrar

Box 68760, Division of Vital Records, P.O.

or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-transit been signed by the should be detached certificate hes birector, page 2 si director After 24 hours after death.

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permit. Pages 1 and 2 Department of Health a important: If item 27 ie eny injury or other trai once.

Physician

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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traumatic event, the Medical Exeminar must be notified at

/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š Be Completed 25. Was case referred to medical 27. Manner of Death Certification: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09834 April 13,2006 Collaco 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2005^{32. Redistrar's Signature}

3720 Farragut Avenue Kensington, Md 20895

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year SARBARA ADELAIDE 6:04 PM A91.1 11 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balt, more 50 Baltimore Mospital NIA 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 💢 F Hours 213-34-3959 Director Yrs. SEPTEMBER 6,1957 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 No MARYLAND BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö KEYWORTH 2404 Ітеть 23а S.A. . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Itel Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 🗷 No Specify: BLACK þ Specify. 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compi Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL WORK SOCIAL SECURITY ADMIN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental WILLIAM EVELYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other traisonce. JOHN SATCHELL JR. (SON) 2404 KEYWORTH AVE, BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MARYLAND NATIONAL CEM. 04-17-2006 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME GINON: FULTON AVE, CALTIMORE, MD 01217 ulumo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician SEP313 /Medical Due to (or as a consequence of): Examiner Non-Small Cell Long Cancer Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Day Year 4□Pregnant at time of death signed by the at d be detached for 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ₩ No 1 Yes 2 No or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 € No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide o the Hospital 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Li Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Apr. 1 11, 2006 KES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore SINAL DO shen 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2006 Registrar

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		1 - For State Registrar	State of Marylan		artment of tificate o		Mental Hy	/giene	06	1774
fig. fo th		1. Decedent's Name (First, Middle, Las	it)				2. Date of D Month_		Voer	3. Time of Death
Physic /Med		LYMAN W	AYNE SOUDER				April	12^{Day}	2006	9:50 a M
Exam		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Dea	ath	4c. Cou	nty of Death	
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Funera Directo			7. Age (In yrs.	ast birthday) Yrs.	If Under 1 Yes Months Day			irth lay, Year) 26, 194	9. Birthp Cour 7 Mar	lace (State or Foreign htry) yland
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Art		, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
th the	ired	10e. Street and Number			10f. Zip Code	•		10g. Citizen	of What Cour	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or items 23e or 28a-f show eny injury or other traumatic event. The Medical Exemples must be rightliad at mone.	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2XXIIIo If Yes, Give Year or Dates:	I	Was Decedent of f Yes, specify Ci t ☐ Yes 2000	f Hispanic Origin? (uban, Mexican, Pue lo <i>Specify:</i>	Specify Yes or N into Rican, etc.)	o- 14. F E Spe	Race - Americ Black, White, cify: W.	
hin 72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i> College (1-4or 5+)	(Give life. L		cupation ne during most of w ired)	orking	16b. Kind of	Business/In	dustry
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Meni &	2	Lyman Lewis Souder	£		_	Emma F	rances S	herman		
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and and lealth m 27		Kathy Marie Souder				ideo Road	and the second of the second	, Mary		20794
ges 1 First First Part of Part		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	nemoval moni State		sition (Name of natory or other p		Date	20c. Locatio	n - City or To	wn, State
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w requires been sign should be	ted by	Chronic Alcoholism								ably 4 □Unknown
ding Physician: The law h.h. h. After this certificate has b.	Completed						24a. Was auto perf 1 Yes	psy ormed?	prior to cor death?	osy findings available inpletion of cause of
ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only	one)		
Phys this	2	1 Yes 2 XX 27. Manner of Death	1 Inpatient 2 I	R/Outpatient 28b. Time of	3 DOA		Home 5 XXes			')
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre			28f. Location (City or To	(Street and Nur wn, State)	mber or Rura	l Route Number,
te Hospita 1.24 hours te Funera	Medical C	29a. Certifier Check offin 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinat and manner stated.	vledge, death on and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the surred at the time,	cause(s) and date and place	manner as st e, and due to	ated. the cause(s)
To th within To th comp	Me	29b/ Signature and title of certifier)			29c. Lice	nse number		29d. Date sign	ned (Month, i	Day, Year)
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10		Alegado, Flib. A	Ampleted cause of death (Item 115 Ritchie Hi	ghway	•	yn Park,	Marylan	đ 2122	5	
Si Regis	tate trar	31. Date filed (Month, Day, Year) APR 1 4.2	32. Agistrar's Signat	ure A	action .					

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1 19g	Dhysisi		1. Decedent's Name (First, Mid								2. Date of D	eath Da	y Year	3. Time of Death
	Physici /Medic		ERic	Smith							April	4	3000	
	Examin		4a. Facility Name (If not institute		um <i>ber)</i>		A .		Location		•	4c.	. County of Dea	ath
			Bos Jewas								/ /			
	uneral irector		5. Social Security Number 230-72-3142 Usual Residence of Decedent	6. Sex 1 M 2 ☐ F	7. Age (In yrs	. last birthday) If Under Months	Days	If Under Hours	Min.	8. Date of 8 (Month, L) 5 – 26 -	Day, Year) -58	9. Bii C V	rthplace (State or Foreign ountry) 'A
and	M TI		10a. State 10b. Coun	ty	10c. C	ity, Town or L	ocation							10d. Inside City Limits
Many	두를	to	MD		Ва	altimo	ore							1 X 1Yes 2□No
ING Z IZ 13-UU30 be filed within 72 hours after deeth with the Maryland	or 28e be not	by Funeral Director	10e. Street and Number 1881 Edmonds	son Ave.			10f. Zip	Code 212	1 7			1 7	tizen of What C	ountry?
aeth v	18 230 Tuest	era			cedent Ever in	16 12				rigin 2 /Co.	naifu Van ar h		14. Race - Am	orican Indian
ter de	Tien I	Š	11. Marital Status XXNever Married 2☐ Marr	Armed F	orces?	J.S. 13.	If Yes, spec	ify Cuba	n, Mexica	in, Puerto	ecify Yes or N Rican, etc.)	40-	Black, Whi	
J.S. af	l', or	by	3 ☐ Widowed 4 ☐ Divorce	If Yes G	2 X No live Dates:		1 ☐ Yes 2	XX ₀	Specify	:			Specify: B	lack
L 13-0030 thin 72 hours af	atura	ted	15. Deced	ent's Education		16a. Dece	edent's Usua	Occupa	ation			16b. K	ind of Business	s/Industry
hin 7	Med "	ple	(Specify only high Elementary/Secondary (0-12	est grade completed	(1-4or 5+)	life.	e kind of wor DO NOT us	e retired	<i>uring</i> mos)	st of work	ing			
d wit	E 4 4	Completed	10th		(, , , , , , , , , , , , , , , , , , ,	La	abore	r				Sai	nitati	on
	r oth	Be (17. Father's Name (First, Middle		_						e (First, Midd	le, Maiden	Sumame)	
Viario	ment arked atic e	ပ	Clarence H.	Smith, Si	· .				The	ıma	Wake			
Viar 12 sh	7 le m rraum		19a. Informant's Name/Relation Nicole Smith				-				al Route Num	-	or Town, State,	Zip Code)
1 and	m 2 ther		20a. Method of Disposition		20b.	Place of Disc	osition /Nam	se of	· · · · · · ·	г	Date	_	ocation - City or	r Town State
Dallimor	Department of Health and Mentain rigides. Department of Health and Mentain rigides. Proportment if them 27 is marked other then "natural," or liems 23a or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at once.		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from (Specify)	State Ba	cemetery, cre ayviev	omatory or of Crei	mato	ory	4-10	0-06		ndalk,	
permit.	Import eny inj		21. Signature of Funeral Service	extremsee		- 1					-		is,JR MD 212	
			23a. Part1. Enter the disease, shock, or heart failure. U	complications that	caused the dea									Approximate
Dhy	ysician		Immediate Cause (Final					-						Interval Between Onset and Death
	ledical		disease or condition resulting in death)		O (or as a conse		1,2	10/10	_710	~				
Exa	aminer				7 (01 43 4 001130	qu oneo oi).								
#.	36	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	o (or as a conse	quence of):								
petn	dansit	Examiner	Cause (Disease or injury that initiated events	1.										
fou, te be executed	an an rial-tr	Exa	resulting in death) Last	Due to	o (or as a conse	quence of):								
	ysicie ne bu	cal		d										
di a	as th	Med	15 55440 5											
ath cer	endir use	J.	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		□Ectopic pre	anancy					23d. Date of de	
deal D	been signed by the ettending physicien and should be detached for use as the buriat-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (spe						Month	Day Year
, #	by the	hy	9 Unknown											
es the	gned be de	þ	Part II. Other significent condi	tions contributing to	death but not re	sulting in the	un derlying ca	ause give	en in Part	I.				to the cause of death?
w requires	been si should		-								1	Yes 2	□No 3□P	robably 4 Unknown
2 × ×	as be 2 sh	Completed									24a. Wa	s an	24b. Were a	utopsy findings available completion of cause of
E PE	ate h page	E									per 1 ☐ Yes	formed?	death?	s 2□No
ician: 1	ctor	Be	25. Was case referred to media examiner?	al		/			26. Plac	e of Death	h (Check only	one)		
Physic	his ce I dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatie	ent 3 DO	A Othe	er: 4 □ N	ursing Ho	me 5□Re	sidence	6 □Other (Spe	ecify)
= g	fter ti		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a. Date (Mo	of Injury onth, Day Year)	28b. Time Injury	of 2	8c. Injury Work	at		28d. Describe	how inju	ry occurred	
Attending	or: A	catl	2 Accident inves	stigation			М	10	Yes 2					
V All	rect rect	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 288, Plac	e of Injury - At I ding, etc. <i>(Spec</i>	nome, farm, s	treet, factory	, office			28f. Location City or T	(Street ar	nd Number or Fi a)	Rural Route Number,
ם פון	ral D													
UNISION OF VITAL RECORDS, F.O. BOX 66 To the Hospitel or Attending Physician: The law requires that the death certifical subsequents of the death certifical subsequents.	winning the Funeral Director, and to make the properties of the pr	Medical		ying Physician: To the al Examiner: On the and ma										
o th	rompl compl	Me	29b. Signature and title of certification	ier			29c	License	number			29d. Da	te signed (Mon	th, Day, Year)
F :	> = 0		M. b. a. 1	N w la	^		0	77	94	x30		Ann	1601	20x1
-	V		30. Name and address of person	on who completed car	use of death (Ite	m 23a) (Tvne	, Print)	_ / /	1-1	000		114/1	, 4	7000
1	1		DA/ESE R.	Binu M	0 20	200 IV	ا لاله	Baltin	nort.	54	1 Y 330	Balti	none !	e to the cause(s) th, Day, Year) > 000 Ylyry/Aud
St. white	Sta	ite	31. Date filed (Month, Day, Yea	(r) 32.	Registrar's Sign	ature	1 10	~ IVIV		- 14		, , , , ,		1/ 20-2
	Registr	ar	MDD 1	1.2006	PACIAL O	15 B	13-11	,						
DHMH 1	17 Rev 1/2	001	MIN 1	1	6.3	-								

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	artmen e <i>rtificati</i>			and Me		iene _{eg. No.}	06	11776
	Dhisial	an	1. Decedent's Name (First, Middle,							Date of Deal Month	th Day	Year	3. Time of Death
	. Physicia /Medic	_	THELMA							APRIL	9	2006	8:15 AM
}	Examin	er	4a. Facility Name (If not institution,			4b. City,		Location o		=	4c. Cc	ounty of Death	
***			5. Social Security Number 6		ge (In yrs. last birthday	/) If Under		LT//				9. Birth	place (State or Foreign
	Funeral Director		224-36-4965	1 □ M 2 🟋 F	75 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 2 - 1 1 -	31 1	VA	intry)
	<u>م</u>		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I								10d. Inside City Limits
	anyla shov	'n	MD 10b. County		Balti								1XXYes 2 □ No
	the M	ecto	10e. Street and Number			10f. Zip	Code			1	Og. Citizer	n of What Cou	intry?
	with 3a or	ă	607 N. Brice S	Street			1217	7			u.s.		
	death ms 2:	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13	. Was Deced	dent of Hi	spanic Ori	gin? (Spec	city Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
9	after or its	/Fu	1 Never Married 2 Marrie	d 1 ☐ Yes 21X	NNo .	1 🗌 Yes		Specify:		nouri, otc.,	Sı	pecify: B1	_
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or itams 23e or 28e-f show the Modical Exercifier most be notified at	d by	3	If Yes, Give Year or Dates		edent's Usua	al Ossuma	tion				of Business/li	
15	n 72 n nat	Completed	15. Decedent's (Specify only highest	grade completed)	· (Giv	e kind of wo DO NOT u	rk done d	luring mos	t of workin	g	TOD. KING	OI DUSINGSAN	idustry
712	with lene.	omp	Elementary/Secondary (0-12) 12th	College (1-4or	5+)	Cler	k				Pos	tal	
פ	e filed within al Hygiene. I other than " vent, ILO Mis	BeC	17. Father's Name (First, Middle, La	est)				18. Mothe	er's Name	(First, Middle,	Maiden Su	ımame)	
<u>Ja</u>	2 should be and Mental is marked o	To	Clarence Wakes	sa				(un.	<u> </u>				
Maryland	2 sho		19a. Informant's Name/Relationshi Tonya Smith	p (Type, Print)		-				Route Number Ve. Ba			
e, P	toges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene if item 27 is marked other than "naturel", or itams 23a or 28a-f show or other traumatic event, II.e Medical Exactinar must be notified at		20a. Method of Disposition					_		_		tion - City or T	
nor	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other once.		1 ☐ Burial 2 ▼ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	20b. Place of Dis cemetery, cr			9) 4	4-13	-06			
Baltimore,	artme		21. Signature of Furnial Section Li							sley C			
B	Depa impo eny ii		//stal	Mario						. Balt		D 212	31
A	Physician /Medical Examiner	<u>.</u>	23a. Pan1. Enter the discrete, or conshock, or heart tailine. List of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. ACL Due to (or a	ad the death. Do not eline. ITE M (C) s a consequence of): UERE s a consequence of):	CAR	DIA	16	Cardiac of	ARCTI	est,		Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the as been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. LU		CAN	CE	R					
O. Box	at the death certific: by the attending pl	Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	3 ⊟Ectopic p 5 ⊟ Other (sp					230	d. Date of deli Month	very Day Year
S, D	es tha igned l	by P	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying o	cause give	en in Part I					the cause of death?
Records,	w require been si should b				•					1 U Y	es 2	No 3∏Pro	babiy 4 dinknown
ecc	e law re has be je 2 sho	Completed								24a. Was a autop perfor	an sy	24b. Were au prior to death?	topsy findings available completion of cause of
E		S									2 N o		2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ar.		Check only or		704 (0	
ō	Phys r this sral di	. To	1 Yes 2 No 27. Manner of Death	1 Inpa	jury 28b. Time		28c. Injun Worl	4 111		ne 5 🗌 Resid 28d. Describe h			iny)
ion	Attending I r death. ector: After by the funer	atlor	1 Natural 5 Pending 2 Accident investiga		Day Year) Injun	м		k? Yes 2 □	No				
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of	njury · At home, farm, etc. (Specify)	street, factor	y, office		2	28f. Location (S City or Tow		Number or Ru	ral Route Number,
ā	rs after ral Dire	Cer											
	Hosp 4 hou Fune fely fil	edical	(Check only 2 Medical E	Physician: To the be- xaminer: On the basis	of examination and/or								
	To the Hospital or Attenwithin 24 hours after deal Volume 1 to the Funeral Director: completely filled in by the	Med	one) 29b. Signature and title of certifier	and manner	Stated.	29	c. Licens	e number			29d. Date	signed (Monti	n. Day, Year)
	₹. <u>₹</u> .8		1 Ron I	P (1)	uzm.				3 (7				
,	0		30. Name and address of person y	no completed cause of	death (Kem 23a) (Tyr	pe, Print)	~	50	, 33	•	111/4	06	1,2006
1	1		KOSITA R	CRU.	Z M- Z)	1301	4 5	SE(OUR	5	HOSP	ITAL
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)		strar's Signature	will !							

			1 - For State Registrar	State of Mar		artment of Hertificate of L		R	eg. No.	1777
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic		Lillian Strzegows					April	11, 2006	4:40 A. M
7	Examin	er	4a. Facility Name (If not institution, give Gilchrist Center	street and number)		4b. City, Town, or		1	4c. County of Dear	
			5. Social Security Number 6. Sec	7 Age /	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	0.0:	ce County
	Funeral Director) Yrs.	Months Days	Hours Min.	Month, Day Dec . 06	(1915 Wier	thplace (State or Foreign ountry)
	D		Usual Residence of Decedent							
	how	_	10a. State 10b. County		Oc. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f e	Director	Maryland Baltimore	e County	Towson					1 ☐ Yes 2 ☐ No
	vith th	<u>=</u>	10e. Street and Number			10f. Zip Code	1 20 4	1	0g. Citizen of What Co	•
	s 23g	erai	20 Stone Manor Cou				1204		United Sta	
36	should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. The Hygiene marked other than "raturel" or liems 23e or 28e-f show matic event, the Madical Exemities must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I □ Yes 2점 No	spanic Origin? (S) i, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, Whit	
2-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Deced	ient's Usual Occupa	tion		16b. Kind of Business	Industry
215	thin 7	Be Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College, (1-4or 5+)	(Give	lent's Usual Occupa kind of work done d OO NOT use retired)	uring most of wor	king		
2	filed wil Hygien ther th	Con	12	n/a	Telep	hone Oper	ator		C&P Teleph	none Co.
_	m - 0 5	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
<u> </u>	ould Men Marke	ို	Joseph Sagan					ne Surdyk		
Maryland 2121	12 sh hand 7 ie m rraum	1 1	19a. Informant's Name/Relationship (Ty Mrs. Joan A. Marde			g Address <i>(Street</i> a. Stone Manc			; City or Town, State, 2 1, Maryland	Zip Code) 21204
e)	1 and Healt em 2	1	20a. Method of Disposition	II (Daugiree)	20b. Place of Dispo				20c. Location - City or	
Š	ages nt of t: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ F	emoval from State	cemetery, cren Evans Fun	natory or other place) !			11, Maryland
altimore,	artme ortane Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	99 0 -		~	,	-		-
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked eny injury or other traumatic events.		1 Jeffrey J	-, gair	Az, Pe	aceful Al 25 York R	ternátiv oad Ti	res Funer Monium,	al&Cremati Maryland 2	on Ctr.,P.A.
П			23a. Parly. Enter the disease, or complishock, or heart failure. List only or	cations that caused the cause on each line.	e death. Do not ent	er the mode of dying	, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ACI)te	STrok	e			weeks
П	Examiner		f	Due to (or as a o		ASCU LAN	1150	400		
۵		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a c		45CO CAN	0.136	MJE		gean
	uted J ansit	Examiner	Cause (Disease or injury	00						0
o.	execting and inal-tra	Exa	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):					
68760	ficate be executed physician and s the burial-transit	edical		l						
	ntifica ng ph as th		IF FEMALE:							
Вох	w requires that the death certi been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 [Ectopic pregnancy			23d. Date of del	
	the a	SICI	1 Yes 2 No	4□Pregnant at tim 9□Unknown	ne of death 5	Other (specify)			Month	Day Year
o.	hat the	윤	Part II. Other significant conditions cor	tributing to death but r	not resulting in the ur	derlying cause give	in Part I	23e Did tob	pacco use contribute to	the cause of death?
Vital Records,	The law requires that the te has been signed by th vage 2 should be detache	d b	a on asene	of rich	t Lea	065	truetu			obably 4 □Unknown
ö	v requ	Completed	tung disc	Or :	1	1 000		-		
He He	has ge 2	d L	every acse	7732				24a. Was a autops perforn	y prior to death?	topsy findings available completion of cause of
		ပိ	25. Was case referred to medical					1 Yes 2	1 ☐ Yes	2 🗆 No
5	Attending Physician: The laving death. ector: After this certificate has by the funeral director, page 2	To B	examiner?	ospital:	2 ☐ ER/Outpatien	Other		th (Check only on ome 5 Reside		
ם ס	g Phy erthi		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury Work			w injury occurred	(1) Suce
<u>o</u>	ath.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1	ea <i>r)</i> Injury		es 2 No			
É	al or Atters at a ster de i Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	eet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director; Aft completely filled in by the fur	Medical C	29a. Certifier (Check only one) 1 Certifying Physical Cartifying P	sician: To the best of ner: On the basis of ex and manner stated	amination and/or inv	occurred at the time estigation, in my opi	, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To th To thin compl	Me	29b. Signature and title of certifier	1 .0		29c. License	number	25	d. Date signed (Monti	h, Day, Year)
)			> Il thather	7 Rile	, und	12.	5205	1	April 11	,2006
10	7		30. Name and address of person who co	mpleted cause of deat		Print) A/ //	1	(+ L	lto. Md	2/2016
74	Sta	te	31. Date filed (Month, Day, Year)	32. Segistrar's	G701 Signature	14. CM	aces,		40.1010	-120/2
	Registr		APR 1 / 20	06 /	. H. An	BAEL!				

		1 = For State Registrar	State of Maryland / Department of Health a Certificate of Death		giene 0 6 1 1 7 7 8
Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) 4a. Facility Name of not institution, give s	treet and number) 4b. (ity, Town, or Location o	2. Date of Dea	
Funeral Director	(5. Social Security Number 6. Sex 10 11 11 11 11 11 11 11 11 11 11 11 11	M DEF 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Yrs. Months Days Hours	24 Hrs. 8. Date of Birt Min. Month, Day	h, Year) 9. Birthplace (State or Foreign Country)
ne Maryland 8a-f show	ector	10a. State 10b. County Ballin	wore Windsor Mill		10d. Inside City Limits 1 □ Yes 2 No
eath with the is 23a or 2	Funeral Director	3227 Southgree	040		10g. Citizen of What Country?
within 72 hours after death with the Maryland ene.	þ	1 ☐ Never Married 2 ☐ Married 3 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes, specify Cuban, Mexican If Yes, specify Cuban, Mexican If Yes, specify: 1 ☐ Yes 2 No Specify: Year or Dates:	in? (Specify Yes or No-	Specify: Black
Definition (e.), Intally idea (a. 1.2.1.3.1.00.3.0) permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendel Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28a-f show eny injury or other treumetic event, the Medical Eventrate must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+) College (1-4or 5+) Avrs 16a. Decedents Usual Occupation (Give kind of work done during most wife. Po NOT use retired) Avrs		Battomare C. Ly Schools
at yidilid Kilk should be filed with nd Mental Hygiene marked other the metic event, Itel	To Be	77. Fither's Name (First, Middle, Last) On. Informant's Name/Relationship (Ty,	18. Mother 18. Mother	ie Mae	Maidon Sumame) Y. City or Town, State, Sip Code)
Te, Ival		Kowena Smith - M 20a. Meghod of Disposition	Crea/Daughter 3027 Southgree 120b. Place of Disposition (Name of 12)	(/ /	sor Mill MD 21244 20c. Logation - City or Town, State
Dallillo permit. Pages Department of Importent: If it eny injury or o		Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Cense	emoval from State Cemetery A Name and Address of Facility	1-13-2006 Free ne. E.	Libertytown, MD
permit. Depart Import eny inj		23a. Part1. Enter the disease, or compli	Steen 87282. Berty & cations that caused the death. Do not enter the mode of dying, such as	d Randa cardiac or respiratory an	rest, Approximate
Physician /Medical		shock, or lead failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line. CANDIAC ANNEST Due to (or as a consequence of):		Interval Between Onset and Death
Examiner	iner	Sequentially list conditions, if any, leading to immediate notes. First Indenying Cause (Disease or injury	Due to (or as a consequence of):		
of ou, sate be executed by sician and the burial-transit	cai Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):		
Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ NO 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed be should be deta	þ	A	tributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to the cause of death? es 2 No 3 Probably 4 Dunknown
VICAL DECOLOR Sicien: The law requ contilicate has been irector, page 2 should	Completed			24a. Was a autop perfor 1 🗆 Yes	sy prior to completion of cause of
ding Physicien: The ding Physicien: The The After this certificate he funeral director, page	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	26. Place ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nur	of Death (Check only of rsing Home 5 Resid	ne) lence 6 □Other (Specify)
ng ng		27. Manna of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Month? 28c. Injury at Work? 1 Yes 2 N	28d. Describe h	ow injury occurred
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune funerel.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Rreet and Number or Rural Route Number, m, State)
te Hospi 24 hou ne Funer sletely fil	Medical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	ician: To the best of my knowledge, death occurred at the time, date and ler: On the basis of examination and/or investigation, in my opinion, deat and manner stated.	d place, and due to the o h occurred at the time, o	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within To the comp	M	29b. Signature and title of certifier	G Len DOO36		April 11, 2006
5	1 8		mpleted cause of death (Item 23a) (Type, Print) W 2411 W. Belvede	re # 301	April 11, 2006 6 BAUT MD 21215
Sta	ite rar	31. Date filed (Month, Day, Year) APR 1 4 200	32 Registrar's Signature		

06-02459 Sullivan, John

Physicia Medical Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transit

Division of Vital Records, P.O. Box 68760,

- For State Registrar		d / Departm <i>Certific</i>	ate of D		A IVICII(6	aı⊓y(Reg. No	200	6 117
. Decedent's Name (First, Middle	e,Last)					2	Date of De	eath		3. Time of Death
	WRENCE	SULLIV	AN				April 10,	2006	Year	14:59
Ia. Facility Name (if not institution 1260 Trappe Road	n, gi ve st reet and numb	er)		City, Town, or L Street	ocation of	Death			c. County of Di Harford	eath
Social Security Number	6. Sex 7.	Age (In yrs. last bir	• •	f Under 1 Year	If Under	24Hrs.	8. Date of E	Birth (MN	//DD/YYYY), 9.	Birthplace (State or F
219-50-5879 sual Residence of Decedent	1 XM 2 F	54	Yrs.	Months Days	Hours	Min.	3–19	-195	2	Country) MARYLAND
Da. State 10b. County		10c. City, Town	or Location							10d. Inside City L
	FORD			STRE	EET					1 Yes 2
De. Street and Number			10	of. Zip Code				10g. Cit	izen of What C	Country?
1260 TRAPPE ROA	A D			2115	54				U.S.	Α.
	12. Was Decederried Armed Force 1 Yes			ecedent of Hisp specify Cuban,				lo-	14. Race - An White, etc	merican Indian, Black, c.
	rced If Yes, Give Year or Dates:		1 Ye	s 2 X No	specify:				Specify: V	WHITE
15. Decedent's Education (Speci		during		Jsual Occupation	on (Give kin	nd of wor	k done	16b.	Kind of Busine	
Elementary/Secondary (0-12)	College (1-4 c	or 5+)		king life. DO NO NIST	T use retir	ed)		М	ARTINS	MARTETTA
'. Father's Name (First, Middle, L	_ast)			18	8 Mother's	Name (F	irst, Middle,	Maiden	Surname)	
GEORGE a Informant's Name/Relationshi	ip (Type, Print)	SULLIVAN 198	o. Mailing Ad	dress (Street	JANE and Numbe		al Route Nu		HLEPEGE	
KATINA SALISBUR	RY/ DAUGHTE			INDEN A					E, MD	21206
a. Method of Disposition Burial 2 X Cremation		20b. Place of		(Name of ceme			Date		•	or Town, State
Donation 5 Other Spe			O CREM	ATORY	4	1-14	-2006	C	ATONSVI	ILLE, MD
Signature of Funeral Service,L	icensee	_	22. Name	e and Address of						
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State Registrar

31, Date filed (Month, Day, Year)
APR 1 4 2006

Ana Rubio MD.



ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

2. Date of Death

3. Time of Death

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Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.	important: if item 27 is marked other then "naturel", or Items 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinating must be notified at

April 12, 2006 ear Physician Schnabel Edith Berdell 2:05 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8828 Walther Blvd. Apt. 2309 Parkville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, 1991) 9. Birthplace (State or For August 1, 1913 Pennsyl vania 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 ☐ M 2 🙀 F 194-03-5267 92 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No Baltimore Baltimore MD Completed by Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8820 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellen Hall George Harrold Dora 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6039 Glen Arm Road Glen Arm, Maryland 21057 Eileen King- Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 4/17/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 Pearl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Backerial preumonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 certificete has b irector, page 2 sl 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Natural 5 Pending death. 1 Yes 2 No 2 ☐ Accident investigation within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1758646 2006 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna Monics Bou 10 va rd 8800

DHMH 17 Rev 1/2001

State Registrar

31. Date liled (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrer	State o	f Maryland		artmen <i>rtificat</i>					iene	006	1781
	Physici	an	1. Decedent's Name (First, Middle								2. Date of Deatl	h Day	Year	3. Time of Death
	/Medio				June So	llanek						ril 9,	2006	8:50 a.m. ^M
	Examir	er	4a. Facility Name (If not institution				4b. City,	Town, or	Location of			4c. 0	County of Death	
-	Funeral		5. Social Security Number	6569 Beech	WOOd dr. 7. Age (In yrs. Ia:	st birthdav)	If Under	1 Year	If Under		umbia 8. Date of Birth	1		oward
В	Director		219-20-2251	1□M 2 X F	78	Yrs.	Months	Days	Hours	Min.	(Month, Day,	-		place (State or Foreign intry)
	pu ,		Usual Residence of Decedent		10- 01-	-					June 8, 1	927		Tennessee
	laryla shov	'n	10a. State 10b. County		Toc. City,	Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 No
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פַ	be illed within 72 hours after death with the Marylan ital Hygiene. Id Hygiene. Id other than "natural", or Items 23a or 28a-f show event, it a Marical Examination at	Be C	17. Father's Name (First, Middle,	Last)							(First, Middle, M	laiden S	Surname)	
<u>lar</u>	should be filed withir ind Mental Hygiene. s marked other than umatic event, ILE M.	ToE	Williar	n P. McLaugh	lin						Pe	arl S	Smith	
Maryland 21215-0036	2 No 20 12		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	or or Rura	al Route Number,	City or	Town, State, Zip	o Code)
<u>د</u> د	t and tealth sm 27 ther tr		Ms. Deborah Hov	well Da	ughter	1 ce of Dispo			er Rd.		River, Man			
Baltimore,	Pages nent of H int: If ite iry or of		1 X Burial 2 ☐ Cremation			netery, crer	natory or o	ther place	9)		_		ation - City or To	
量	permit. Page Deportment Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (S ₁ 21. Signature of Funeral Service		Cr	est Law	n Memo				12/2006	N	// Arriottsville	e, Maryland
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ï			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that controls on a	aused the death.	Do not ent		871 A	ld Colu	mhia l	Diko Ellicott	City, I	MD 21043	Approximate
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	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	nce of):								
8760,	icate be executed physician and s the burial-transit	dical		d.										
9	tificat ng phy as thi	ledi												
Вох	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnand		Ectopic pre	agnancy				23	8d. Date of delive	•
0	e dea the at hed fo	slci	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregn 9☐Unkno	ant at time of deal	th 5□	Other (spe	ecity)					Month	Day Year
<u>а</u>	uires that the dei signed by the a Id be detached f	Phy	Part II. Other significant condition	ns contributing to de	eath but not resulti	ing in the ur	nderlying ca	ause nive	n in Part I		23e Did toba	acco use	e contribute to the	he cause of death?
Records,	signe d be		,				idonying de	4030 g. VO	ir iir i Qirt i.		1 ☐ Yes	~		
cor	w require	lete									24a. Was an			ppsy findings available
_	he fa e has age 2	Completed									autopsy perform	ed2	prior to con death?	mpletion of cause of
Vital	sician: The law s certificate has b lirector, page 2 s	ø	25. Was case referred to medical						26. Place	of Death	1 Yes 2 Check onlone	No	1 🗆 Yes	2)(No
>	Physical this certail direction	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🔲 I	npatient 2 EF	3/Outpatien	t 3 🗆 DO	Otho	r	rsing Hor	11		☐Other (Specif	iy)
u o	ding Pl h. After th funera		27. Manner of De Th 1 Natural 5 ☐ Pending	28a. Date of (Mont	of Injury 28 th, Day Year)	8b. Time of Injury	28	Bc. Injury Work		2	28d. Describe how	v injury (occurred	
Sio	ttendi death. ctor: A / the fu	catl	2 Accident investig	ation			М		es 2 🗆 N	-				
Division of	l or Al after of Direction by	Certification:	4 Homicide determine	ned 28e. Place buildii	of Injury - At hom- ng, etc. (Specify)	e, farm, stre	et, factory,	, office		2	28f. Location (Stre City or Town,		Number or Hura	al Route Number,
_	spital tours neral filled		29a. Certifier 1 Certifyin	Physician: To the	best of my knowle	edge, death	occurred a	at the time	a. date and	d place, a	and due to the cau	ise(s) ai	nd manner as si	tated
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medicel I	xaminer: On the ba and mann	asis of examination	n and/or inv	estigation,	in my opi	inion, deat	h occurre	ed at the time, dat	e and p	lace, and due to	the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	1 00			29c.	License	number		290	d. Date	signed (Month,	Day, Year)
	4		Men /	Elle	<u> </u>		0	131	161	3	_ /-	pri	111.20	006
	10		30. Name and address of person v	C-11.	210	3a) (Type,	Print)	Q	1	-	011/2	1	1000	7107-
-	Sta	10	31. Date filed (Month, Day, Year)	0	egistrar's Signatur	Th La	V/C/) Nin	n 1	4	Clad	40	NN(A)	210/5
	Registr		APR 1 4	2006	Mare K	La	rether					v.		
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and Syfranski 4.74-06 9.A.M. Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

nysicia		1 - State Registrar Amend Item 1. Decedent's Name (First, Middle, Las	271	y G854 4/ na K. Szaf		2. Da	Reg. Note at the state of Death fonth	av Year 3. Time	e of Death
Medica xamine		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo			c. County of Death	Pt.
neral		Social Security Number 6. S	Friendship Plac	CE e (In yrs. last birthda	y) If Under 1 Year If	Columbi Under 24 Hrs. 8. Da	ate of Birth	Howard 9. Birthplace (State Country)	te or Foreic
ector		175-12-7535	□M 2MF	86 Yrs.	Months Days	Hours Min. (N	nonth, Day, Year ruary 15, 19		
3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			10d. Inside	/
erstifiedat	Director	Maryland Ho 10e. Street and Number	oward		Ellice 10f. Zip Code	ott City	10a C	1 ☐ Y	es 2 1.1
ast fee		4519 Stonecrest Dr.			101. ZIP 0000	21043	109.0	U.S.A.	
only joury or other treumatic event, It., Medical Etaria actional be rutified at one.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Note: Married 4 Divorced	12. Was Decedent E Armed Forces 1 □ Yes 2 N If Yes, Give Year or Dates:		B. Was Decedent of Hispa If Yes, specify Cuban, I 1 Yes 2 No 5	anic Origin? (Specify Y Mexican, Puerto Rican Specify:	(es or No- l, etc.)	14. Race - American Indian Black, White, etc. Specify: White	,
Medical I	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5	(Giv	eedent's Usual Occupation ve kind of work done during DO NOT use retired)	ng most of working	16b. i	Kind of Business/Industry Healthcare	
ic event, I	To Be Co	17. Father's Name (First, Middle, Last)	es Kozak			es Aid . Mother's Name <i>(Fir</i> si		n Sumame) Levitsky	
reuma		19a. Informant's Name/Relationship (7						or Town, State, Zip Code)	
other		Mrs. Pat Knapp 20a. Method of Disposition	Daught	20b. Place of Disp	4519 Stonecrest position (Name of templace)	Dr. Ellicott City		ocation - City or Town, State	}
jury or	'n	1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	<i>'</i>)	Mt	Airy Cemetery	04/12/2	2006	Natrona, Pennsylv	ania
eny in		21. Signature of Fluneral Service Liben	Vas Rught	Mn1292	22. Name and Address of Slack Fur	f Facility neral Home, P <i>.F</i> Columbia Pike	Α		
	- 1		one cause on each in	10.	anter the mode of dying, s	uch as cardiac or resp	oratory arrest,	Interval E Onset ar	nd Death
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	_	·	For State Registrar	State of Ma		d / Depa	artme	nt of H		Mental Hy	gien Reg. No	e) ()	5 	1783
	Physicia /Medic Examin	al	Norma Collins To A. Facility Name (If not institution, give	odd			4b. Cit	y, Town, or	Location of Dear	-	11,	2006 c. County o		3. Time of Death 5:00 P
	uneral rector		215-10-2210		(In yrs. la	as <i>t birthday)</i> Yrs.		er 1 Year	rville If Under 24 Hrs Hours Min		rth a <i>y</i> , <i>Year</i>	Baltir Baltir		ace (State or Foreign try) Land
th the Maryland	or 28a-f show e natified at	lrector	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10e. Street and Number			Town or Lo	m 10f. 2	ip Code			10g. C	itizen of W		0d. Inside City Limits 1 ☐ Yes 2 ☑ No
5-0036 72 hours after death with the Maryland	Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic event, the Madical Exeminar must be notified at once.	by Funeral Director	8725 Blairwood Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	d, Apartm 12. Was Decedent E Armed Forces? 1 □ Yes 2 数数 If Yes, Give Year or Dates:	ver in U.S	S. 13. \	Was Dec	236 edent of H ecrify Cuba 2824No	ispanic Origin? (§ in, Mexican, Puer Specify:	Specify Yes or Noto Rican, etc.)		14. Race Black Specify:	, White, e	
Maryland 21215-0036 to 2 should be filled within 72 hours afills and Mental Hygiene.	er than "natura , the Madical E	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5-	+)	16a. Deced (Give life. L	kind of v DO NOT	ual Occupi rork done d use retired	during most of wo	rking		Kind of Bus	siness/Inc	
aryland should be file	marked oth	To Be C	17. Father's Name (First, Middle, Last) Robert E. Collins 19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailin	g Addre	ss (Street a	18. Mother's Na Mary Whe and Number or R					^{Code)} , 21236
Baltimore, Ma Dermit. Pages 1 and 2 Department of Health a	t: If Item 27 Is y or other trai		Gary Todd (Son) 20a. Method of Disposition 1%Description 3 F Other (Specify)	lemoval from State	ce	8725 ace of Dispo	Blai	TWOOC	Road,	Apartmer Date	1t B- 20c. L	-1, B	alto City or To	., Má! ²³⁶
Baltir permit. P	Importan any Injur pace.	2	21. Signature of Funeral Service Licens			22	. Name	and Addres Bri OLC I	izdžinsk Lastern	i Funera Avenue,	al Ho Mary	ome,	P.A.	F 181
/Me	sician edical miner		23a. Part 1. Aler 1 e disease, or compi short, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line LUNG CAN Due to (or as a	e. ICER		er the m	ode of dyln	g, such as cardia	c or respiratory a	arrest,			Approximate Interval Between Onset and Death
ox 68 / 60, certificate be executed	ysicie 1e bu	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a d.										
P.O. BOX 6	y the attending pached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at the 9 □ Unknown	2 🗌 Fetal (death 3□	lEctopic Other (pregnancy specify)				23d. Date Mont		ry Day Year
P G	hould	Completed by Pi	Part II. Other significant conditions cor	ntributing to death bu	t not resul	lting in the ur	nderlying	cause give	en in Part I.	10	Yes 2	□No 3	3 🗌 Proba	, A
	his certificete has t I director, page 2 s	Be Comp	25. Was case referred to medical examiner?				-171		26. Place of De	24a. Was auto perfo 1 ☐ Yes ath <i>Check only</i>	psy ormed? 2X No	pr	ere autopior to con eath? Yes	sy findings available pletion of cause of 2 □ No
on o	After ti unera	2	1 ☐ Yes 2 😿 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ☐ Inpatier 28a. Date of Injury (Month, Day		R/Outpatien 28b. Time of Injury	t 3□ t	28c. Injury Work	4 Nursing r	dome 5 Resi				HOSPICE
Division spital or Attending hours after death.	To the Funerel Director: After th completely filled in by the funeral	ai Certification:	3 Suicide 4 Homicide 29a. Certifier 29a. Certifier	28e. Place of Injubuilding, etc.	. (Specify) f my know	riedge, death	occurre	d at the tim	ie, date and place	City or To	cause(s	e)	ner as sta	Route Number,
To the Hospital or within 24 hours after	To the Fu completely	Medical	(Check only one) 2 Medical Examination 29b. Signature and title of certifier	ner: On the basis of and manner stat	examinatio	on and/or inv	estigation	n, in my op 9c. License	pinion, death occu	urred at the time,	date an	d place, an	nd due to	the cause(s) Day, Year)
7 33	Sta Registr		30. Name and address of person who con the control of the control	2300 DU	LANE	Y VALL		D, 7	TIMONIUM	, MD 210				

DHMH 17 Rev 1/2001

APRIL 11, 2006 5:00 p.m.

NORMA TODD

			For State Registrar	State o	f Marylar	-			ealth a	and M		Reg. No.)06		17	8
PH	nysicia		Decedent's Name (First, Middle	, Last)				_			2. Date of Dea Month	Day	Ye		3. Time (
	Medic	al -	MICHAEL	F.		TIL		, Sr.	Location of	- Doath	04	12	20 County of D		/:35	A M
E	xamin	er	4a. Facility Name (If not institution) FOREST HILL HE				1	REST		Death			HARFO			
Fu	neral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Und	er 1 Year	If Under		8. Date of Birt	h	9	Birthpl	ace (State	or Foreign
	ector		213-14-8000 Usual Residence of Decedent	½ ∏M 2□F	85	Yrs.	Months	Days	Hours	Min.	July 5	192	.O N	Count lary	land	
/land	ם		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10	0d. Inside (City Limits
Man Man	fied	ctor	Md. Harfo	rd		A	bing	don							1 🗌 Ye	s 2 No
with the	The rice	I Dire	10e. Street and Number 2963 Harrogate	Way			10f. Z	ip Code 210	09			U.S.	en of Wha	t C <i>ou</i> ni	try?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. The marked other types a nation and Mental Hygiene.	Examinermus	by Fur	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed Fo	2 □ No ve		If Yes, sp	ecify Cuba	ispanic Ori in, Mexicar Specify:	i, Puerto	ecify Yes or No- Rican, etc.)		4. Race - / Black, V Specify:	Vhite, €	etc.	
A I A I D-UUSO ad within 72 hours af rgiene.	Vazisat	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed)		16a. Dece (Give life.	dent's Us kind of w DO NOT	ual Occupi rork done d use retired	ation during mos	t of work	ing	16b. Kin	d of Busin	ess/Ind	lustry	
d with	폌	HO	12 years	College		chemi	cal	labor	atory	teo	ch.	ste	e1			
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aryland should be f and Mental H	natic	2	Sabatino Tibur			10h Maili	na Addro	ns /Stroot			Vasti al Route Numbe	or City or	Town Sta	to Zin	Code)	
Man d 2 st lith and	treur		Michael F. Tib								bingdon				0000)	
Sattimore, bernit. Pages 1 ar Department of Hea	or other	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	Place of Dispo cemetery, crea			3		Date 15/06		ation - City			
IT Pa	njury	1	4 ☐ Donation 5 ☐ Other (S _i 21. Signature of Funeral Service		Sa	cred H							lalk,			_
	any r		VIII-11	111							Home or					
Exam	dical niner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to	(or as a consec	guence of):	shic	- 0	dio	ves	eu lu	Jos	Cel.Co	10	Approxima Interval Be Onset an	etween
Hecords, P.O. Box 68/60, The law requires that the death certificate be executed	igned by the attending prysician and be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[\text{Yes} \ 2 \end{array} \] No 9 \[\text{Unknown} \]	d	(or as a consect theome of pregnicity 2 Fetter nant at time of the comment of	ancy al death 3[⊒Ectopic ⊒ Other (pregnancy specify)	,			2	3d. Date o		ory Day	Year
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VITA ician:	ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only c					
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DIVISION al or Attending s after death.	od in by the	Certification:	3 Suicide 6 Could determ	not be 28e, Plac	e of Injury - At h	nome, farm, st	reet, facto	ory, office			28f. Location (City or Tou			or Rura	l Route Nu	ımber,
To the Hos, ital	ne runer	Medica (29a. Certifier (Check only one) Contifying	g Physician: To the lead mail	e best of my kn pasis of examin oner stated.	owledge, deal ation and/or in	th occurrenvestigation	d at the tir	ne, date ar pinion, dea	id place, ith occur	and due to the red at the time,	cause(s) date and	and manne place, and	er as st due to	ated. the cause	o(s)
To the within	comp	ž	29b. Signature and take of certifie		-		2	9c. Licens				9d. Date	signed (A	Aonth, I	Day, Year)	
1			17/26	270	CACP			H39	102	2	/	tori	112	2	006	2
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Service of	· .	2	31. Date filed (Month, Day, Year)	RESTI, 13	08 BUSI Registrar's Sign			R) WAY	, 501	TE I	102; ED0	HWOO	D, M) 7	1040	
F	Sta Registi			2006	10 10	Appel										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#22.perFH_C854_4/J4/06_TL/_Construct of the library and Manage Indexed

Amend item#22,perFH C854 4/14/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Dorothy Ev 2. Date of Death 3. Time of Death Theroux April 9 Day 2006 Year Evelyn **Physician** 11:13am /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/15/1927 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 ☐ M 2 🔀 F 79 215-22-0184 Maryland Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at MD Montgomery Wheaton 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12602 Dalewood Drive 20906 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. , or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: 3 ☐ Widowed 4 ₺ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry American College other then Elementary/Secondary (0-12) Colfege (1-4or 5+) Secretary of Radiology 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipury or other traumatic event stoke. Be William H. Gonce Caroline M.Ennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colette J.Nelson/Daughter 1726 Paradise Blvd.Rockford, Illinois 61103 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/17/06 Silver Spring, Md Gate of Heaven 4 □ Donation 5 □ Other (Spybity) 22. Name and Address of Facility Philip D. Rinaldi Funeral Service, P.A. 21. Signatur of Funeral Service Licensee 9241 Columbia Blvd. Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mms /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ormed? 212 No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours at To the Funeral Di Lartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 290 Signature and title of certifier 29d. Date signed (Month, Day, Year) 050987 4-10-06 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) agilhers burg 10 BOX 83819 31. Date filed (Month, Day, Year) APR 1 4 2006 32. Registrar's Signature State Registrar

			For State Registrar	Sta			/ Depa		t of H	ealth a		lental Hy		HILL	11786
			Decedent's Name (First, Midd.	e, Last)					-			2. Date of De		,,-	3. Time of Death
	Physici	_	MAURICE	WILS	'ON	TT.	ULL					Month April	12, Da	2006	3:30 A M
	/Medic	-	4a. Facility Name (If not institution				ОГГ	4h City	Town or	Location of		VALIT		. County of Deat	
	Examin	er	Alice Byrd Taw	-				VD. Oity,		sfiel			10		merset
			5. Social Security Number	6. Sex		ge (In yrs. la:	st birthday)	If Under		If Under:		8. Date of Bir	h		
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			Usual Residence of Decedent				2					August	201	1940 146	itytanu
	/land		10a. State 10b. County			10c. City,	Town or Lo	ocation							10d. Inside City Limits
	Man H + sh	ţò	Maryland Som	erset				(ris	field					1 ☐ Yes 2X No
	28a	Director	10e. Street and Number	CLUCC				10f. Zip		11010			10g. Cit	tizen of What Co	untry?
	aa oi		26532 Mariners	Poad					2	21817				USA	
	72 hours affer death with the Maryland natural', or Itams 23a or 28a-f show Jisal Examiliar must be indiffed at	Funeral	11. Marital Status	12. Wa	s Deceden	t Ever in U.S.	13.	Was Deced			gin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race - Ame	ncan Indian,
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Maryland	2 should be and Mental is marked (sumarked)	-	19a. Informant's Name/Relations	hip (Type, Pri	int)		19b. Maili	ng Address					er. City o	or Town, State, Z	(ip Code)
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of	Phys r this ral dii	_	27. Manner of Death	28a	. Date of Ini	urv 2	8b. Time o					me ⊃∟ Hesi 28d. Describe I		6 □Other (Spec	erry)
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	spita ours naral filled		29a. Certifier 1 ₹ Certifyi	ng Physician:	To the bes	t of my knowl	edge, deat	h occurred	at the tim	ie, date an	d place.	and due to the	cause(s) and manner as	stated.
	To the Hospital or Attending I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	edicai	(Check only 2 Medical one)	Examiner: Or	n the basis id manner s	of examinatio	n and/or in	vestigation,	in my op	pinion, deat	th occur	red at the time,	date and	d place, and due	to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifie	or				290	. License	number			29d. Da	te signed (Month	o, Day, Year)
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	~		30. Name and address of person	who complete	ad cause of	death (Item 9	3a) (Type	Print\		1 33	3			1 / 02	
10	1		Vijasz Karumhur	athan	MD	- 201	Hall	High	17217	- Cri	afia	ald. Mar	- Typ-	nd 21215	7
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/Medic			ELEN THOMAS						pril		2006	7:30 a M
Examin	er	4a. Facility Name (If not institution, give s.	treet and number)		4b. Cit	, Town, or	Location of De	ath		4c. Count		
Funeral Director	2	1424 Maryland Aver 5. Social Security Number 6. Sex 215-09-8640		last birthday) Yrs.	If Und Months	er 1 Year	Vern If Under 24 H Hours M	rs. 8.	Date of Birth (Month, Day, Yay 21,	(ear)	9. Birth Cou Ma	ndel place (State or Foreign intry) ryland
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with ti	盲	10e. Street and Number			10t. Z	ip Code			100	g. Citizen of		
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21215-0036 d within 72 hours af giene. r then "natural", or the Madical Exam.		15. Decedent's Educ		16a. Dece	dent's Us	ual Occupa	ation		16	Sb. Kind of E	Business/Ir	ndustry
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and and eath m 27		Larry Robert Thoma				-	Avenue	So Date	evern,			
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altimore, mit. Pages 1 a partment of Hes portant: If tem y injury or othe		4 □ Donation 5 □ Other (Specify)					tory 4/	17/	2006	Odent	on, M	aryland
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at			mao		onal 411	dson Annap	olis Ro	oad		n, Ma	ry, F rylar	od 21113
P		23a. Part Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	cations that caused the deat e cause on each line. Askers public							it,		Approximate Interval Between Onset and Death
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c 68 antifice ing ph	Physiclan/Med	IF FEMALE:										
Box 61 leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	ıl death 3[pregnancy					ate of deliv	ery Day Year
the degraph of the a	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of o	leath 5[Other (specify)						
IS, P.O. I		Part II. Dther significant conditions con	tributing to death but not res	sulting in the t	nderlying	cause give	en in Part I		23e. Did toba	cco use cor	tribute to	the cause of death?
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al h		-							1 ☐ Yes 2√	No No	1 🗌 Yes	2₹ No
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On ding	it or	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		<br Yes 2 □ No					
Division of Vital Records, P.O. Box 68760, or or attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physicien and in by the funeral director. page 2 should be detached for use as the burial-transit.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)	reet, facto	ory, office		28f.	Location (Stre City or Town,		ber or Rui	ral Route Number,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 € Certifying Phys (Check only 2 Medical Examin one)	ician: To the best of my known the control of the basis of examinating and manner stated.	owledge, deat ation and/or in	h occurre	d at the tim on, in my or	ne, date and pla pinion, death or	ace, and	due to the cau at the time, dat	ise(s) and m e and place	anner as and due	stated. to the cause(s)
omple	Me	29b. Signature and title of certifier			2	9c. License	number -		290	d. Date sign	ed (Month	, Day, Year)
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1		30. Name and address of person who co	mpleted cause of death (Iter	n 23a) (Type,	Print)		- 1	,		^		
4		CHARLES R.	GRAHAN	7 - /	001	PI	Ne H	945	AVE-	BAL	10 1	wof
Sta Registi		31. Date filed (Month, Day, Year) APR 1 4 20	32. Bigistrar's Sign	ature	caste	3						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 14 per in per in 354 4-20-16 vt.
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** Month 6:19AM GERALD WAYNE こう WHITE 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA BAYVIEW HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 100 M 2□F Yrs. MD R18.74.0745 Director 03.02.1965 Usual Residence of Decedent the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral, or Items 23e or 28e-f show Examiner must be notified at 17 Yes 2 □ No NA BALTIMORE Directo MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2604 WEST WOODWELL ROAD 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 06 Never Married 2 ☐ Married white Specify: 8LAC Baltimore, Maryland 21215-0036 1 ☐ Yes 2 15 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "netural" Completed other then "netur 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC RECREATION 10 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F SHIRLEY DALE RAY WHITE LOU CARTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) t of Health : LULA MAE NICKEL 2604 W. WOODWELL RD. BALTIMORE 21222 MO 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State '4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD GREENMOUNT 04.14.06 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATU PIKE, BALTO. MD 21229 21. Signature of Funeral Service Licensee any ir aughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cardiomyrioth disease or condition /Medical resulting in death) Due to (or as a consequence of **Examiner** Theresclare Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ► Yes 2 □ No 24a Wasan certificate has 1DR Yes 2 No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1. ☐ Inpatient 2 ☐ ER/Outpatient 3 ■ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 | Homicide within 24 hours a
To the Funerel I
completely filled 1 S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D33634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOWRE DR SUITE 309 BAIT MD ER37 ZOUET, MS FRANKLI DINK 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

DHMH 17 Rev 1/2001

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		•	1 - For State Registrar	State of Ma	ırylan				lealth a Death	and M	ental Hy	/gien Reg. Ni		5	1178	9
	Physici	an	1. Decedent's Name (First, Middle, Las	•							2. Date of D Month	eath Da	ay `	rear	3. Time of De	eath
Υģ	/Medic	al		ttman							April				1:06 E	о М :
	Examin	er	4a. Facility Name (If not institution, give Greater Baltimor		Cont	o r	40. Cr		r Location o WSON	or Death			c. County or Balti			
	Funeral		5. Social Security Number 6. S	ex 7. Age		last birthday)		ler 1 Year	If Under 2		8. Date of B			9 Rintho	lace /State or F	Foreign
	Director	ļļ	030 14 3331	□M 2X)F	85	Yrs.	Month	s Days	Hours	Min.	Aug. 0	8, 1	920	New	York	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside City	Limits
	Mary -f sho	to	Md. Baltim	ore	Tiı	monium									1 🗌 Yes 2	No K
	n the	Director	10e. Street and Number				10f.	Zip Code				10g. C	itizen ol Wh	nat Cour	itry?	
	23e c	ralD	10 E. Aylesbury	Rd.			21	093				U	SA			
	er der Iteme	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13.	Was Ded f Yes, s	cedent of H pecify Cuba	ispanic Orig an, Mexican	gin? (Spe , Puerto l	cify Yes or N Rican, etc.)	0-	14. Race Black,	- Americ White,		
36	illed within 72 hours after death with the Maryland Hygiene. ther than *naturel', or lieme 23e or 28e-f ehow int, the Madical Examinar must be notified at	ا کے ا	1 ☐ Never Married 2 ☐ Married 3 【 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo		1 🗌 Yes	2 🔀 No	Specify:				Specify:	Wh	ite	
21215-0036	72 hou	Completed	15. Decedent's Ed	ducation		16a. Dece	dent's U	sual Occup	ation during most	t of working		16b. l	Kind of Bus	iness/Inc	dustry	
21	ithin 79.	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	00 NO1	use retired	duning most d)	O WORK	ig		0			
2	iled w Hygier Iher th	Co	12 17. Father's Name (First, Middle, Last)			Home	emak	er	19 Motho	r's Namo	(First, Middl	a Maida	0wn			
auc	d be f entel ? ked ol	To Be	Charles Pauli							arie		Lipp		,		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelih and Mentel Hygiene. Importent: if Item 27 is marked other than *naturel; or Items 23a or 28a-f show shy injury or other traumatic avent, the Madical Examiner must be notified at ancie.	-	19a. Informant's Name/Relationship (and Numbe	r or Rura	Route Num	ber, City	or Town, S		Code)	
	and 2 Belth a n 27 in		Mr. James R. What	tman/ Son		6314	4 Mo	ntery	Road	Elkı	ridge,	Md.	2107	5		
altimore,	Tof He		20a. Method of Disposition 1 Day Burial 2 Cremation 3	Removal from State	0	face of Dispo emetery, crer	natory o	r other plac			ate		ocation - C			
Ē	t. Pag rtmen rtent: rjury		4 Donation 5 ☐ Other (Specific	v)	Du	laney \		_		4-18-			moniu	m, M	d.	
Ba	Depermine Depermine Important in Early		21. Signature of Furteral Service Licer	12			± 05	U Yor	k Ra.	LOW:	al Hom	d. 2	nc. 1204			
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only				er the m	ode of dyin	g, such as	cardiac o	respiratory	arrest,			Approximate Interval Betwe	
1	Physician		Immediate Cause (Final disease or condition resulting in death)	aSt	VO!	Le									Onset and De	
	/Medical Examiner		(Counting in County)	Due to (or as	a conseq	uence of):										
	عسا	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseq	uence ol):										
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that intitated events	c												
Ö,	oe exe clan al urial-t	EX	resulting in death) Last	Due to (or as	a conseq	uence ol):										
68760,	icate be executed physician and s the burial-transit	edicai	•	d			-									
•			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	ıncy							23d. Date	ol delive	NOV.	
P.O. Box	res thet the death certif Igned by the ettending be deteched for use a	Physiclan/M	in the past 12 months?	1☐Live birth 4☐Pregnant at				pregnancy (specify)	<u>'</u>				Mont		Day Ye	ar
Ö.	et the by th	hys	9 Unknown	9□ Unknown												
	Attending Physician: The law requires thet the death certi rideath. sctor: Atter this certificate has been signed by the ettending by the inneral director, page 2 should be deteched for use a page.	þ	Part II. Other significant conditions of	ontributing to death be	ıt not res	ulting in the u	nderlyin	g cause giv	en in Part I.						e cause of dea	
0.0	w requir been sl should	Completed									-	Yes 2	2 12000 3	Prob	ably 4 □Uni	KNOWN
Rec	has t	mpi									24a. Wa aut	s an opsy formed?	pri	ere auto or to cor ath?	psy findings av npletion of cau	ailable ise of
ē	in: Th	e Co	25. Was case referred to medical						00 81	-(5. 0	1 ☐ Yes	2 N	0 10	Yes	2 2 (No	
Ē	ysicia is cert direct	To B	examiner? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	Hospital:	nt 2 🗆	ER/Outpatier	nt 3 🗆	DOA Oth	00		<i>(Check only</i> ne 5□Res		6 □Other	(Specif	/)	
0	ng Ph ter thi		27. Manner of Death	28a. Date of Inju (Month, Da	v	28b. Time o		28c. Injur Wor			28d. Describe				·/	
Sign	endir. eath. or; Af	catic	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	1			М		Yes 2 1	No				_		
Division of Vital Records,	after d after d Direct d in by	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju- building, etc	ıry - At ho :. (Specif	ome, larm, str y)	eet, lact	ory, office		2	28f. Location City or To	(Street a	ind Number te)	or Rura	l Route Numbe	er,
	To the Hospital or Attending Physicien: The Is within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page.	Medical C	29a. Certifier 12 Certifying Ph (Check only one)	ysician: To the best on the basis of and manner sta	examina	wledge, death tion and/or in	h occurr vestigati	ed at the tin	ne, date and pinion, deal	d place, a	and due to the	e cause(s	s) and man	ner as si	ated. the cause(s)	
	ro tha vithin ro tha	Me	29b. Signature and title of certifier	and mailler sta			1	29c. Licens	e number			29d. D	ate signed	(Month,	Dey, Year)	
	- 3F 0		Cyntuia Sr	viand	20			000	5513	47		1	+/1:	2/	060	
	25		30. Name and address of person who	completed cause of d	eath (Iten	n 23a) (Type,	Print)	1001	St F	Balti	MACO	MI	1 217	nu .		
	Sta	te	31. Date liled (Month, Day, Year) APR 1 4 2	32 Registra	ar's Signa	Ulgo /	ast,	1	- (- /-			7-11	, 0,0	7		
	Registr		APR 1 / 2	MARIE A	2.0 1	J. 649	100									

Whattam, An

		1 - For Stata Registrar	State of Maryla			Health and		_	11790
Physic	ian	1. Decedent's Name (First, Middle, L Louis	ast) Lloyd		Voumeh 1 oo		2. Date of Death Month	Day Year	
/Medi Exami		4a. Facility Name (If not institution, g			Youngbloo	or Location of Deal	APRIL	10 2-00 4c. County of Dea	
Exami	ner	ST. AGNES		RC-		TIMO		N/A	au i
Funeral Director		213 22 2000	Sex 7. Age (In yr.	5. last birthda 77Yrs.	// If Under 1 Year Months Days			1929 M	rthplace (State or Foreign country) aryland
/land		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or I	Location				10d. Inside City Limits
a-fsh	ctor	Maryland Anne A	rundel G1	en Bur	nie				1 ☐ Yes 2 No
death with the Maryland ms 23a or 28a-f show mant be notified at	Funeral Director	10e. Street and Number 109 Forest St.			10f. Zip Code 210	61	10	g. Citizen of What C	ountry?
ire, INIBITYIBIIG Z.I.Z.I.D-UUJO s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "nature!", or items 23a or 28a-f show other traumatic event, Ine Medical Examinar must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No		Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify: Ame	
72 ho	eted	15. Decedent's I (Specify only highest g		16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of wo	rking	6b. Kind of Business	s/Industry
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retire inist	nd)		Railroa	ad
Id A	0	17. Father's Name (First, Middle, Las	ot)			18. Mother's Na	me (First, Middle, M		
Viand outd be file Mental Hy arked oth attic event	To B	Leslie L.	Youngblo	od		Iva D	ean Blar	nche Sho	oemaker
Mar d 2 sho th and 7 is my traum		19a. Informant's Name/Relationship					ural Route Number,		Zip Code)
e, n 1 and 1 and Health em 27 ther t		Wilma L. Sands (2) 20a. Method of Disposition		Place of Disc	osition (Name of		Burnie, MI		Town State
ages ant of l at: If its y or o		1 ABurial 2 □ Cremation 3 i	Removal from State	cemetery, cri	ematory or other pla	_{се)} erv 4/14		oc. Location - City of Baltimore.	, Maryland
Dallimore, permit. Pages 1 an Department of Heat Important: If item 2 eny injury or other		21 Signature of Fundal Survice Lie	ny)				ıdon Park		•
		MAN Main	•				., Baltimo		
Physician /Medical		23. Ran. Enter the disease, or of strick, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	a	PNE		ng, such as cardia			Approximate Interval Between Onset and Death
Examiner			Due to (or as a conse	quence of):					_ ,
	ner	Sequentially list conditions,	b. — Due to (or as a conse	quanda of):					
icate be executed physician and sthe burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
e be ex sician	ical E	Todaming in dodainy case	Due to (or as a conse	quence of):					
oo/ ificate g phys			_ d.						
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnance □ Other (specify) _	y		23d. Date of de Month	livery Day Year
that the ed by detac		Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause gr	ven in Part I	23e. Did toba	cco use contribute to	o the cause of death?
quires t quires t n signe	d by	CHRONIC	OBSTRUCTUE	PUL	MONARY	DISEASI			robably 4 Dunknown
aw reco	Completed						24a. Was an	24b. Were a	utopsy findings available
The The ete he	E O				"		autopsy performe	d? death?	completion of cause of
Cian: Cartific ector,	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only one)		
Phys ral dir	5	1 Yes 2 No 27. Manner of Death	1 💹 Inpatient 2 L	ER/Outpatie	nt 3 DOA	^{1er:} 4 ☐ Nursing H	lome 5 Residen	ce 6 □Other (Spe	ecify)
th.: After	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	k? Yes 2⊡No	28d. Describe how	injury occurred	
lai or Atter s after dea bi Director ed in by the	Certification:	3 Suicide 6 Could not l	De Disco et leive. Att	nome, farm, si ify)			28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
n 24 hour n 24 hour he Funera pletely fills	Medical (29a. Certifier 1 Certifying P (Check only one) 2 Madical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, dea ation and/or in	th occurred at the tir evestigation, in my o	ne, date and place	, and due to the cau rred at the time, date	se(s) and manner as a and place, and due	s stated. e to the cause(s)
To ti withi To ti comp	Σ	29b. Signature and title of certifier	~ 0 -		29c. Licens			. Date signed (Mont	
/		> Suvalch				19923	1	PRIL 1	0 2006,
5		30. Name and address of person who	ALA KOMPE	LIA,	Print)	TAGNE	s Hospin	AL, BAL	TIMORE, MD
Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	W.				

DHMH 17 Rev 1/2001

YOUNGBLOOD, LOUIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AMORTH Year Physician 2125 2006 Allen Mariorie Virginia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Jan 21, 5. Social Security Number **Funeral** 1 □ M 2 □ F MD 220-10-7716 87 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a. State 28a-f show in then "naturel", or iteme 23a or 28a-f ehoven and Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Allegany Oldtown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21555 USA 19009 Oldtown Road SE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 is marked other then *naturel; or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) May (Moreland) Haugh Edgar M. Haugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) daughter 16110 Oaktree Lane Williamsport MD 21795 Judy O'Hara 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4/10/2006 Department of Important: If any Injury or once. Oldtown Cemetery MD Oldtown 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE CARDIORETPINATORY ARREST **Physician** /Medical Due to (or as a consequence of) Examiner ANEMIA SEVERE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed use as the burial-transit GASTROINTESTINAL BLEED attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day. in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 2 No certificate the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death | Check only one Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours after To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Madhous Hubbly 04-06-06 62562

DHMH 17 Rev 1/2001

State

Registrar

WASHINGTON

31. Date filed (Month, Day, Year)

HAGERSTOWN

MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHAVI HUBBLY

HUSPITAL

Registrar's Signature

COUNTY

APR 1 4 2006

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death **0525** 10d. Inside City Limits 1 ☐ Yes ŽŒNo Approximate Intervel Between Onset and Death 5 years 5 years

Certificate of Death Reg. No. Amend Item #8 Per FH :854 4/20/06 JH 2. Date of Deeth 1. Decedent's Name (First, Middle, Lest) Month Mary Alice Armstrong **Physician** 30, 2006 March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street end number) Examiner Deer Ridge Manor Cecil Pising Sun Hours Min. A Date of Birth 26
A Dril 27, 9. Birthplace (Stete or Foreign 1913 OF If Under 1 Year 5 Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□ M 2√F 92 Yrs 221-01-1694 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10a. State MD ortant: If Item 27 is marked other then "netural", or Items 23a or 28a-1 show injury or other treumatic event, the Mactical Examiner must be notified at Rising Sun Cecil Director 10g. Citizen of What Country? 10e. Street end Number 1126 Ridge Rd. 10f. Zip Code 21911 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health end Mental Hygiene. Important: If Item 27 is marked other then "netural" or Item any Injury or other treasment. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0020 δ 3 Widowed 4 □ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Secretary 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Braunstein's College (1-4or 5+) Elementary/Secondery (0-12) 18. Mother's Name (First, Middle, Meiden Sumame) 17 Father's Name (First, Middle, Last) Be Alfred H. Williams Alice Gibbonev ၉ 19b Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) W. Green Ln. Milford, DE 19963 Alva W. Hemshrot (niece) 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Gracelawn Mem. Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Dipper (Specify) 4/4/06 New Castle, DE 22. Name and Address of Facility McCrery Funeral Home 3924 Concord Pike, Wilmington, DE 19803 21. Signature of Funeral & rvi Allow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a. CHF Minglistive h
Due to (of es a consequence of): Examiner Examiner artery ettending physician and for use as the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Directo (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of): 23b. Did tobecco use contribute to the cause of death? sate hes been signed by the e page 2 should be detached to Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 No 3 Probably 4 Unknown Atrial Fibrillation 2 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Tes SKINO 1 ☐ Yes 2 ☐ No I or Attending Physicien: The after death.
Director: After this certificate I 25. Was case referred to medical examiner? the funeral director, 26. Plece of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funerel D completely filled I Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) hulle, 29c. License number 29b. Signature and title of certifier 000048050 Deesles 3/31/06 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) # 400 Aberdeen MD 2100] Shukla, MD 15 South Parke Street Prashant 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 1 2006 Registrar

	1	State of Maryland / Department of Health and	Mental Hygiene
Physicia		1. Decedent's Name (First, Middle, Last) Ruth M. Buckley	2. Date of Death Month April 10, 2006 3. Time of Death 8:30 p
/Medic Examin	-	4a. Facility Name (If not institution, give street and number) 1050 Bishop Walsh Rd. 4b. City, Town, or Location of De Cumberland	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 F	Ars. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Nov. 1, 1910 Maryland
Maryland -f ehow		MD Allegany Cumberland	10d. Inside City Limits 1 ☐ Yes 🛂 No
with fhe		10e. Street and Number 1050 Bishop Walsh Rd. 10f. Zip Code 21502	10g. Citizen of What Country? USA
od within 72 hours after death with the Maryland gjene. er then "natural", or lieme 23a or 28a-f ehow r tre Medical Examinar must be notified at	by Funeral	11. Marital Status 1	(Specify Yes or No- erto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
within 72 ene. then "na	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Teacher	working 16b. Kind of Business/Industry Education
be filed ital Hygi od other	To Be Co	17. Father's Name (First, Middle, Last) Joseph Finzel 18. Mother's Lill	Name (First, Middle, Maiden Surname) ie (Weisenborn) Finzel
1 and 2 sh Health and em 27 is m ther traum		Carl Pressman Cousin 81 LaVale Court,	Date 20c. Location · City or Town, State
permit. Pages Department of I Important: if it eny injury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rest Lawn Mausaleum 22. Name and Address of Facility 1302 National	LaVale, MD Hafer Funeral Service, PA Hwy., LaVAle, MD 21502
death certificate be executed was a strending physician and muse as the burial-transit	ical Examiner	23a. Part1. Enter the desease, or complications that caused line death. Do not enter the mode of dying, such as car shock, or heart fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
death certific e attending p id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
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The law requirate has been sl	Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
iling Physician:	To Be	examiner? 1	28d. Describe how injury occurred
To the Hoepital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
e Hoepital 24 hours e Funeral letely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier CROSSE HENNAWI MD D0059	479 4-12-06
Ġ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George Henrain MD 925 Bishop Wals	h Dr. Cumber and, 1402150
St Regis	tate trar	31. Date filed (Workh, Day, Year) APR 1 4 2006	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item #8 Per FH G854 Certilicate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** Αм Robert Louis Beebe, Sr. 03 2006 8:20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Caroline Home for Hospice Denton Caroline If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Oct.17,1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 221-18-9984 74 Delaware Usual Residence of Decedent with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director Maryland Caroline Preston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with Hygiene.
other then "naturel", or items 23e 4157 Payne Road PO Box 321 21655 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 MYes 2 □ No If Yes, Give Year or Dates 1968-84 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be filment of Heelth and Mental Hient: If Item 27 is marked of Raywood Beebe Pauline Harris Beebe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4157 Payne Rd; PO Box 321; Preston, MD 21655 Patricia A. Beebe / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o importent: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Eastern Shore VetCem 3/28/2006 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) orgative Heart tailore **Physician** /Medical Due to (or as a consequence of): 165 Examiner 'homic Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate hes been signed by the atte paga 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Pres 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Atrial 1 Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) HTS pr CQ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Matural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Selle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H42587

555 Cynword Anor Easton MD 21601

29d. Date signed (Month, Day, Year)

23/2006

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			For	State o	f Maryland					and M	ental Hyg	iene			
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and	d be findal H	Be	17. Father's Name (First, Middle,									Maideri St	imame)		
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	()		30. Name and address of person	who completed call	se of death /Item *	23a) (Tyne	Print)				_		11		
	11		Sayed M.	EISWYY	120 9.	7/	Wech	(2)	Cent	er D	n Poc	Kin	Ille. N	10 %	850
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DHMH 17 Rev 1/2001

			. 101	artment of Health and Me rtificate of Death	ental Hygiene Reg. No. 006 11796
			Decedent's Name (First, Middle, Last)	2	2. Date of Death 3. Time of Death
	Physicia /Medic		Evelyn E. Brueckman	М	arch 30,2006 1:30p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			118 Mitchell St.	Elkton	Ceci1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		215-32-5371 1 91 Yrs.		nuary 6,1915 PA
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	/ sho	ō			1 □ Yes 2 □ No
	28a-	Director	MD Cecil E1ktor	1 Of. Zip Code	10g. Citizen of What Country?
	With Sa or		118 Mitchell St.	21921	,
	death with the Maryland ms 23a or 28a-f show must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Speci	fy Yes or No- 14. Race - American Indian,
0	rher	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	If Yes, specify Cuban, Mexican, Puerto Ri	can, etc.) Black, White, etc.
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ဂ	be filed within 72 hours after death with the Marylan delytylien. delytyliene. delytyliene. delyter than "natural; or liems 23s or 28s-1 show avent. It is Madical Examiner must be notified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv	dent's Usual Occupation a kind of work done during most of working	16b. Kind of Business/Industry
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<u>X</u>		은	Louis Angelo	Eliza	beth
Mar	2 sho and is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural F	Route Number, City or Town, State, Zip Code)
e, S	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic			Spring Field Dr	., North East,MD 21901
O DE	0 0		20a. Method of Disposition 20b. Place of Disposered State 20c. Place of Disposered State 20	osition (Name of matory or other place) ate Conception A	
altimor	P P P		`4 □Donation 5 □Other (Specify)	re Conception A	Elkton, MD
<u></u>	permit. Pag Department Important: t any injury o		21. Signature of Eyneral Service Licensee	2. Name and Address of Hacility	
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	8 11.7		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		Interval Between
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	/Medical Examiner		resulting in death) Due to (or all a contequence of):		7
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	othi othi	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	->-0		Genje tiletelle mi	1 8722307	March 3147 2006
	O'i		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	
	0		JAYAN TILAL KVATELINI	123 Singerly Ti	re, ELKTOY, MI) 21921
			31. Date filed (Month, Day, Year) MAR 3 1 2006 32. Registrar's Signature	·	, , , , , , , , , , , , , , , , , , , ,
	Sta	te_	MAR 3 1 2006 Keeper & Courte		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar #29c, perDVR, bg, 4/12/06 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Jane Bennet 23501 M March 24 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Manyand Medical Center Bulhmore Baltimore 6. 9ex 1 □ M 2 X F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Director 230-02-4690 53 05/25/1952 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or Iteme 23a or 28a-f ehov The Medical Examiner must be notified at 1 Yes 2 No Director MD Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30821 West Post Office Road 21853 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify þ 3 Widowed 4 Divorced White ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compl other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Worker none Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Is marked Clinton Kirwan Ada Kirwan Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 and 2 Department of Health a Important: If Item 27 Is Cindy Elza/Sister 11247 East Line Road, Delmar, Delaware 19940 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ò #⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Beechwood Cemetery 4 □Donation 5 □ Other (Specify) 03/29/2006 Princess Anne, MD Signature of Funeral Service Licers of 22. Name and Address of Facility Hinman Funeral Home any Ir YWW00295 11673 Somerset Ave., Princess Anne, MD 21853 Part 1. Enter the disease, or complications that oxyss the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary **Physician** Arrest /Medical Due to (or as a consequence of): Examiner etastute Gastric arcinma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Necrotring Division of Vital Records, P.O. Box 68760 Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown as been signal 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? page 2 No this certificate 1 TYes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 🕱 No 1 & Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death ate of Injury (Month, Day Year) 28a. 29b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident the 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direct in by 4 Homicide within 24 hours a To the Funeral I 🔀 Certifying Physician: To the best of my knowledge, death uncursal at the time. Jate and plane and due to the course(s) and manner as stated 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 8 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000

State Registrar

ASDEEP 31. Date filed (Month, Day, Year)

32. Regismar's Signature

MAR 2 8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUSE CAR

22 songle grane

March

			1 - For State Registrar	State of Mar	ryland .	•	ment of Ficate of			Reg. No.	11798
	Physici	ian	1. Decedent's Name (First, Middle, Las		a	Cmo.	a on		2. Date of D		3. Time of Death
	/Medio		William 4a. Facility Name (If not institution, give	Richaro street and number)	<u>u</u>	Cros		r Location of Dea		4c. County of	
	LAGITIT) 	8941 Old Solomo	ns Island F	Road		Owing			Calve	ert
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last	Me	Under 1 Year onths Days	If Under 24 Hrs Hours Min		irth 9 ay, Year)	Birthplace (State or Foreign Country)
.%	Director		213-42-5559 Usual Residence of Decedent	6	52	Yrs.			July 1	15, 1943 W	lash., D.C.
	yland 10w		10a. State 10b. County	•	10c. City, T	own or Location	on				10d. Inside City Limits
	e Mar	ctor	MD Calve	rt			Owing	gs			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			1	Of. Zip Code			10g. Citizen of Wha	at Country?
	death with the Maryland me 23e or 28a-f ehow rmust be natified at		8941 Old Solomo	ns Island R		13 14/20	2073		Consider Van as N	USA	American Indian,
0	r item	Funeral	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Ye	s, specify Cuba	lispanic Origin? (: an, Mexican, Pue	rto Rican, etc.)		White, etc.
	72 hours after naturel', or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yes Year or Dates:		1 🗆	Yes 2X No	Specify:		Specify:	white
ק	natu	Completed	15. Decedent's Ed (Specify only highest gra		1	(Give kind	's Usual Occup	durina most of wo	orking	16b. Kind of Busin	ness/Industry
7	filed within Hygiene. other then "	dmo	Elementary/Secondary (0-12)	Coflege (1-4or 5+))		drille	•		water	
ב ב	e filed within al Hygiene. I other then '	a)	17. Father's Name (First, Middle, Last)			WCII	arrice		me (First, Middl	e, Maiden Sumame)	
/land	2 should be and Mental is marked o	To B	Raymond Leo	Croson				Elsie	Mae	Moore	2
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Ifem 27 is marked other then "naturel", or iteme 23e or 28e-f ehow titem 27 is marked other then "naturel", or iteme 23e or 28e-f ehow other traumetic event, the M. offel Exempler must be muified at		19a. Informant's Name/Relationship (Type, Print)		_				ber, City or Town, Sta	ate, Zip Code)
_ ນັ	is 1 and of Health item 27 other to		Carolyn S. Croso: 20a. Method of Disposition	n, wife	20h Place	P.O. e of Dispositio		2, Owing	S, MD 20		to as Taura State
2	Pages nent of I int: if ite		1 X Burial 2 □ Cremation 3 □		cem	etery, cremato	ory or other place	_' 1		20c. Location - Cit	
	그 된 본 등 .		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		50.	The state of the s	ame and Addre	dens 04-	01-06	Duikitk,	MD 20736
Ď	Depa Impo eny ii		1 William R	Gran	-	Rau	ısch Fu	neral Ho	me, P.A	., Owings,	MD 20736
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line as a Dissection and the cause of the caused the c	SCM	, nate	1 7)	or respiratory	arrest,	Approximate Interval Between Onset and Death
,0070	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a c. — Due to (or as a					2.0		
J. BUX 00	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, out <i>co</i> me of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	☐ Fetal de	ath 3□Ect	opic pregnancy her (specify)	1		23d. Date of Month	,
Ē	requires that the de sen signed by the a hould be detached f		Part II. Other significant conditions of	ontributing to death but	not resultin	ng in the under	rlving cause giv	en in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
Spico	puires n sign ild be	d by					, .		1 []Yes 2 □ No 3	☐ Probably 4 ② Unknown
S S S		pleted							24a. Wa		re autopsy findings available
Ē,	The ste h	Comple			,				auti per 1 \(\text{Yes}	formed? dea	or to completion of cause of th? Yes 2 No
V [[2]	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?						eath (Check only		
_	hys I dii	5	1 ☐ Yes 2X No	Hospital:			3 DOA Oth	4 Li Hursing		sidence 6 Other	
5	iding Physician: th. After this certifice funeral director, p	tlon	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Bb. Time of fnfury	28c. Injur Wor	yat k? Yes 2 ∐No	28d. Describe	how injury occurred	
Division	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		y - At home (Specify)				28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	the Hospit in 24 hour the Funera pletely fills	edicai	29a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of niner: On the basis of e and manner state	xamination	dge, death oc and/or invest	curred at the tir igation, in my c	ne, date and place pinion, death occ	e, and due to the curred at the time	e cause(s) and mann e, date and place, and	er as stated. d due to the cause(s)
	To T com	Σ	29b. Signature and title of certified	ALT			29c. Licens	e number		29d. Date signed (i	
				11			D.	3312.3		March 30	, 2006
	10		30. Name and address of person who Jonathan Lowenth					Suite 31	0 Prin	re Frederi	ck MD 20679
1000	Sta	ate	31. Date filed (Month, Day, Year) APR 0 3 2005	32. Registrar	Signatur	berte		Jul 00 31	-,	OU LECUCIT	.C., 120 20070
18 B	Regist	rar	LIN A A TAA?	MACHECOS -							

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Joel Collins Mar 24, 2006 5:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick 135 Fairground Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Wash., D.C. 579-64-2083 57 Yrs Director May 16, 1948 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Intem 27 is marked other than "naturel", or Items 23s or 28s-f ehow 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23s or 28s-1 show other treumstic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Prince Frederick Calvert Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20678 135 Fairground Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? → Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Public Schools** Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernestine Boston Joseph Collins 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 Fairground Road Prince Frederick, MD 20678 Darlene Collins/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any njury or ot X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/31/06 Cheltenham, MD Cheltenham Veterans Cemetery 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Sewell Funeral Home 21. Signature of Funeral Service Licensee Blady a. 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocarma disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy Day ò in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by a page 2 should be detect 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to predical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 1 Yes 2 No Medical Certification; To 1 Inpatient 2 ER/Outpatient 5 Residence 6 Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 aturat 5 Pending 1 ☐ Yes 2 ☐ No death 2 Accident investigation s after death the 6 Could not be determined 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funerel D t 🗠 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) napolis Erike 32. Registres Signature 31. Date filed (Month, Day, Year) State 2006▶ Registrar

		1	, FOF	partment of Health and Mertificate of Death		ne 006 1800
4 S			Decedent's Name (First, Middle, Last)	7	2. Date of Death Month	Day Year 3. Time of Death
	Physicia /Medic	_	Lorraine Elizabeth Cardinal		March 26	, 2006 1:00 P. M
1 1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
(1)		Ser y	St. Mary's Nursing Center	Leonardtown If Under 1 Year If Under 24 Hrs.		St. Mary's
724	Funeral		5. Social Security Number 577-24-2400 6. Sex 1 □ M 2X F 7. Age (In yrs. last birthda) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	
	Director		577-24-2400 83 Yrs. Usual Residence of Decedent		Aug. 11,	1923 Washington, DC
	ylanc how	١. ا	10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	e Ma	cto	Maryland Calvert St. Leona	ırd		1 □ Yes 2X No
	ith th	Dire	10e. Street and Number	10f. Zip Code		. Citizen of What Country?
	ath v	ral	4930 Kings Road	20685		nited States
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it item 27 is marked other than "natural", or items 23s or 28s-f show if it item 27 is marked other than "natural", or items 27 is marked or other than "natural", or other treumatic event, it is Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	2 hou		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	b. Kind of Business/Industry
215	within 73 ene. then "n	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	ing	
21	e filed within al Hygiene. cother then "	Completed	12 Hous	sewife		omemaker
73	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)
Z	should be and Mental marked o	၉	Joseph A. Souder	Dorothy		25 - 7 - 0 - 7 - 0 - 4 - 3
Mai	12 sho h and 7 ie m treum			iling Address (Street and Number or Run		
	is 1 and 2 of Health a item 27 ie other tree	-	20a Method of Disposition 20b. Place of Dis) Kings Road, St. I		Malytalia 2000 c. Location - City or Town, State
JO.	Pages nent of int: if it iry or o		1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State	ematory or other place)		TOTAL PRODUCTION AND AND AND AND AND AND AND AND AND AN
Baltimore,	- 독립를	1	Metropo			lexandria, Virginia eral Home, P.A.
B	Depa Impo any ir		1 4 6 5 AL	1405 Broomes Island Roa		·
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or hear failure. List only one cause on each line.			
	Physician		Immediate Cause (Final disease or condition Respit	ratory di	stress	Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):	0		
4	Examiner		Sequentially list profitions b. Colon	Cancer.		
	sit s	lne	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
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687	ficate p phy:	edic	d.			
P.O. Box	that the death certificate be executed ted by the ettending physicien end deteched for use as the burial-transit	Physiclan/Medical		B Ectopic pregnancy Council Other (specify)		23d. Date of delivery Month Day Year
	law requires that the as been signed by th 2 should be deteche	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
rds	quires in sign		Paulinsons	disease.	1 🗆 Yes	2 No 3 Probably 4 Nnknown
00	law requir as been s 2 should	piet	Paulinsons Hypenterroio	_ 1	24a. Was an	24b. Were autopsy findings available
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ita	ien; Th artificete ctor, pag	Be	25. Was case referred to medical examiner?	26. Place of Dear	th (Check only one)	
of <	Physicien: this certific ral director,	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat		ome 5 Residen	ce 6 ☐Other (Specify)
	ding Ph h. After th tuneral	on:	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	/ Work?	28d. Describe how	injury occurred
Sio		icat	2 Accident investigation 3 Suicide 6 Could not be 380 Bloom of laws 4t home farm	M 1 Yes 2 No	28f Location (Stre	net and Number or Rural Route Number,
Division	in the of	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town,	
_	To the Hospital or Attenwithin 24 hours effer deat To the Funeral Director: completely filled in by the	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the cau rred at the time, date	ise(s) and manner as stated. e and place, and due to the cause(s)
	withir To th	¥ e	29b. Signature and title of centrier	29c. License number	290	d. Date signed (Month, Day, Year)
			> Mun	D60888	Ma	arch 27, 2006
	ħ		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)		
	<u> </u>		Rakhi Krishnan, MD 26840 Point Lock	out Rd., Leonardtown, M	Varyland 206	550
No. of London	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 8 2006	foods		

State of Maryland / Department of Health and Mental Hygiene 11 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 23, 2006 **Physician** 8:45 AM M Helen Russell Crouch March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery 7522 Sebago Road 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F 94 Yrs Director 577-07-4201 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, Ihm Moded Examinating to writher an 1 X Yes 2 No Director Maryland Montgomery Bethesda 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 7522 Sebago Road 20817 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify by Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Michael Russell Matilda Bell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard H. Crouch/Son 7522 Sebago Rd. Bethesda, MD 20817-4840 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven March 28, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 1 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Cemetery 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 2222 Wisconsin Ave., N.W. Wash., D.C. 20007 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 years Alzheimer's Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner and -transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No page 2 s certificate 1 Yes 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 2 this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 12890 March 23, 2006 ress of person who completed cause of death (Item 23a) (Type, Print) 15 5410 Conn. Ave., N.W. Jon Wi∳eman, M.D. #117 Wash., D.C. 20015

State Registrar

		1 - For Stata Registrar	State of Ma		/ Depart		of Hea	Ith and N	-		006	11802
		Decedent's Name (First, Middle, Last)		·		mouto .	0, 00		2. Date of De			3. Time of Death
Physicia		JEFFERSON BRODER	ICK COHEN						MARCH 2	3, Day 20	06 Year	6:55 PM
/Medic Examin		4a. Facility Name (If not institution, give s			4	b. City, Tov	vn, or Loc	ation of Death			ounty of Death	
	•	SUBURBAN HOSPITAL				BETH	ESDA			МО	NTGOME	RY
Funeral Director		5. Social Security Number 111-22-0173 6. Sex 1X Usual Residence of Decedent	7. Age	98		If Under 1 Y Months D		Jnder 24 Hrs. ours Min.	8. Date of Bird (Month, Da 11/29/	1 90 7	9. Birth Cot NY	nplace (State or Foreign untry)
then "natural", or items 23a or 28a-f ehow ite Mudical Exact rat must be notified at		10a. State 10b. County		10c. City, To	own or Local	tion						10d. Inside City Limits
r 28a-f ehow rootified at	tor	MD MONTGOME	RY	CHEVY	Y CHAS	E						1 ☐ Yes 2 No
or 28s	Completed by Funeral Director	10e. Street and Number				10f. Zip Co	de			10g. Citize	n of What Co	untry?
23a (alD	8100 CONNECTICUT A	VENUE, #1	605		20	815			U	.S.A.	
er m	ıner	11. Marital Status	12. Was Decedent E Armed Forces?		13. Wa	s Decedent	of Hispai Cuban, M	nic Origin? (Spexican, Puerto	ecify Yes or No Rican, etc.)	14	Race - Amer Black, White	
o.	γFι	1 Never Married 2 Married	1X Yes 2: N If Yes, Give Year or Dates: W	lo T.T.T. T	1	Yes 21						HITE
natural Jical Ex	q pe	3 Widowed 4 □ Divorced 15. Decedent's Educ			6a. Deceden	at's Heuri O	ocupation			10h Kind	of Business/I	ndusta
olf al	olete	(Specify only highest grade	completed)		(Give kin	nd of work d	lone durin etired)	g most of work	king	I OD. KIII O	OI DUSINGSS/I	ridustry
the st	mo	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)		ULTAN				US	GOVERN	MENT
vent, La Mu	BeC	17. Father's Name (First, Middle, Last)					18.	Mother's Nam	e (First, Middle,	Maiden Su	ımame)	
tic e	To B	A. BRODERICK COHE	N				S	ADIE RO	SAHNSKY			
		19a. Informant's Name/Relationship (Ty)	oe, Print)	1	19b. Mailing	Address (St	reet and i	Number or Rui	ral Route Numbe	r, City or T	own, State, Z	(ip Code)
n 27		HELEN SALTZMAN (SI	STER)		4 KIRK			-	HARTFOR	D, CT	06117	
or of		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 ⊠R	emoval from State	20b. Place	of Dispositi	ion (Name o tory or other	of (place)	1	Date 5/2006		tion - City or 1 S CHUR	
d in		4 Donation 5 Other (Specify)		¢ARDE1	DAVID VS			1				
Dependent of health a Important: If item 27 is eny injury or other tre		21. Signature of Funeral Service License	Θ		DÂN 117	Vame and A ZANSK O ROC	ddress of Y-GO] KVIL]	Facility LDBERG LE PIKE	MEMORIA ROCKV	L CHA	PELS MD 20	INC. 852
		23a. Part f. Enter the disease, or complishock, or heart failure. List only or	cations that caused e cause on each lin-	the death. E	Do not enter t	the mode of	dying, su	ich as cardiac	or respiratory ar	rest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	MYOCA	RDIAL	INFAR	CTION						Onset and Death
edical miner		resulting in death)	Due to (or as a	consequen	ce of):							
τ	_	Sequentially list conditions,		Page 12 Your District								
sit	ine	Sequentially list conditions, any, leading to firm available cause. Enter Underlying Cause (Disease or injury	Due to (or as a	s.consequen	GE OI).							
sician and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a	a consequen	ce of):						-	
E G	cai E											
phys s the												
attending phy I for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	of pregnancy						236	d. Date of deli	very
the atte	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2 4☐Pregnant at t			ctopic pre <i>g</i> n Other (s <i>pecil</i>					Month	Day Year
8 2	hys	9 Unknown	9□ Unknown							_		
50	ed by Physician/Med	Part II. Other significant conditions con CONGESTIVE HEART		ut not resultin	ng in the unde	erlying caus	e given in	Part I.				the cause of death?
s been s s should	piet	ATRIAL FIBRILLAT	ION						24a. Was	an :	24b. Were au	topsy findings available completion of cause of
page 2 :	Completed	DIABETES MELLITU	S						autop perfo 1 Yes	med?	death?	2 No
certificete ector, pag	BeC	25. Was case referred to medical			100		26.	Place of Dea	th (Check only o		1 🗆 103	22110
is ig	ToE	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatier	nt 2⊠ER/	/Outpatient	3□ DOA	Other: 4	☐ Nursing H	ome 5□Resid	dence 6 [Other (Spec	city)
h. After thi funeral		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injun (Month, Day	y Year) 28	b. Time of Injury	28c.	Injury at Work?		28d. Describe			
tor: A	cati	2 ☐ Accident investigation				М		2 □No				
od in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	iry - At home :. (Specify)	, farm, street	t, factory, of	fice		28f. Location (S City or Tox	Street and I vn, State)	Number or Ru	ral Route Number,
To the Funeral Director: completely filled in by the	edicai	29a Certifier Samuel Check only one) 2 Medical Examin	incien: To the best of ter: On the basis of and manner state	examination	dge death a and/or inves	ocurred at the stigation, in	he time, d my opinio	ate and plane n, death occur	and due to the rred at the time,	causo(s) ar date and pl	ace, and due	stated. to the cause(s)
То th	Me	29b. Signature and title of certifier			*****		cense nu			29d. Date	signed (Month	n, Day, Year)
		X Y.). '			DI	.96	09		MARCH	24, 20	006
3	13	30. Name and address of person who co		1.5		int)		1				
(10)	Ü	RAMAN R. TULI, MD	10810 DA			., SU	ITE :	202 GA	ITHERSB	URG,	MD 208	78
Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	ır's Signature	e to	aste)						

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Provided a second program of the country of the cou	Ball	permit. Depart Import any in		Vnl-1 1111	R	AYMOND FUNERAL	SERVICE	C, P.A.	
Physician (Medical Examiner) Page Physician (Medical Examiner) Physician (Medical Exam		76 TE		23 Part 1. Enter the disease, or complications hat caused it	ne death. On ot ente	A DIATA, MARYI er the mode of dying, such as cardiac c	ND 206 or respiratory arrest,	46	Approximate
Due to (or as a consequence of):				disease or condition	ESTIVE	HEART FAILT	më.	9	Onset and Death
The standard events of the standard events of				Due to (or as a	consequence of):				
The standard events of the standard events of	Ļ	200	Jer	Sequentially list conditions, b. Due to (or as a cause, Exter) loading to immediate	consequence of):			- 1	
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29a. Certifier (Check only one) 29b. Signature and dittle of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pers numb completed cause of death (Item 23a) (Type, Print) Meindart Smith 12070 old icn Center Surk 100 Waldrif MD 206 52 31. Date filed (Month, Day, Year) 32 Pegistrar's Signature	ivis	r Atter ter des irector n by th	rtifica	3 Suicide 6 Could not be 28e. Place of Injury	y - At home, farm, stre (Specify)	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	! Route Number,
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		•	1 - State Registrar		•		rtificate				,	Reg N	OOC	11804
	hysici	20	1. Decedent's Name (First, Middle, La								2. Date of De Month	ath Da	ay Year	3. Time of Death
	/Medic		John Daniels,					-			March :		2006	8:40 A. M
Ε	xamin	er	4a. Facility Name (If not institution, gir Calvert Memoria)						Location of 'reder				College	
Fi	ineral		5. Social Security Number 6.	Sex 7. Age	e (In yrs. la	ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bir	th	Calvert 9. Bi	rthplace (State or Foreign country)
	ector		351-18-1861	4 X 1 14 2 C C	83	Yrs.	Months	Days	Hours	Min.	(Month, Da		1922 Io	
put	81 E48		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside City Limits
Maryle	e po	٥												1 □Yes 2 XNo
the	28a	Director	Maryland Calvert 10e. Street and Number		St.	Leona	10f. Zip	Code				10g. C	itizen of What C	Country?
death with the Maryland	rsi, or items 23s or 28s-f show Examiner must be notified at	al Di	5875 Julie Court				20	685				Un	ited St	ates
deat	BLUM	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	wer in U.S	S. 13. \	Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race - Am Black, Wh	
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V a	natic :	ပ္	John Daniels, Sr.					(0)			ace Do		- 0	7.00
Mal d 2 sh th and	7 is n traun		19a. Informant's Name/Relationship John Daniels, III				-						or Town, State, aryland	
Tan Heal	if item 2 or other		20a. Method of Disposition		20b. PI	ace of Dispo				100	ate	_	ocation - City o	
IIIMO	lant: If i		1 ☐ Burial 2 ☐ Cremation 3 6 4 ☐ Donation 5 ☐ Other (Speci			ropoli			1	3/29	/06	7.14	vandri:	a, Virginia
mit.	5 E at .		21. Signature of Funeral Service Lice		Meci	22	2. Name and	d Addres	s of Facility	y Rau	sch Fu	nera	al Home	, P.A.
n aa	E & S		1 st. 5. 52	th		4	405 Bro	wies.	Island	d Road	l, Port	Reput	olic, Mar	yland 20676
			 Part1. Enter the disease, or cor shock, or heart failure. List only 	nplications that caused y one cause on each lin	the death	. Do not ent	er the mode	e of dying	g, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Between
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Hospital 24 hours	s Funeral Dirsc letely filled in by	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of miner: On the basis of and manner sta	examinat	wledge, deatl ion and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	and due to the ed at the time,	cause(date ar	s) and manner and place, and du	as stated. ue to the cause(s)
To the within 2	To the complet	Me	29b. Signature and title of certifier	and mannor sta			29c	. License	number				ate signed (Mor	
F 5	F- 0		> and, m	9					390				1271	
مسو ہ			30. Name and address of person who	completed cause of de	eath (Item	23а) (Туре,	Print)							
10	1		ADEED JA	BER 100	D H	05010	m f	20.	Pa	2120	e tr	EDE	RICK,	mp 20678
1 to 1	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	Wasses	d K	Coa	de						

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	Physici	an	Decedent's Name (First, Middle,	,							2. Date of De Month	ath Day	Ye	ar	3. Time of	
	/Medio		Thomas C. De 4a. Facility Name (If not institution,		m <i>ber)</i>		4b. City,	Town, or	Location of		March	28 4c.	_2006 County of D		1:45	p "
		<u>.</u> 10	Howard County	General E	Hospital			ımbia				Н	oward			
	Funeral Director			6. Sex 1 M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)		Country	,	r Foreign
	D		Usual Residence of Decedent		94						Feb.18	,191	2 A	Labaı		
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or Iteme 23a or 28e-f show umatic event, Ira Medical Examinar must be notified at	'n	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d.	I. Inside Cit 1 Tyes	,
	28a-f	Directo	Maryland Baltim	ore	Wo	odsto	10f. Zip	Code				10a Citi	zen of What	t Country		
	3a or		2940 Hernwood R	oad				2116	: 2							
	death	Funeral	11. Marital Status		edent Ever in U	.S. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)	- 1	USA 14. Race - A			
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 🕅 Yes If Yes, G	2 □ No ve		1 □ Yes 2				, , , , , , ,	-	Specify:	************		
8	2 hour	ted t	15. Decedent		MMTI	16a. Dece	dent's Usua					16b. Kii	nd of Busine	Whit ess/Indus		
21215-0036	thin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College ((Give	kind of wor DO NOT us	k done d e retired)	furin g most)	t of worki	ng					
2	i filed wi I Hygien other th	Con	8			Press	Mech	anic					ral_G	over	nment	
Maryland	Duid be fi Mental H arked oti atic ever	Be	17. Father's Name (First, Middle, L						_		(First, Middle,		Sumame)			
ary	should nd Me mark	ဥ	Coy Preston De 19a. Informant's Name/Relationsh			19b. Mailii	ng Address	(Street a		uria er or Ruma	Ada I Route Numbe		r Town, Stat	te, Zip Co	ode)	
	and 2 alth a 27 ls		James P. DeRamu	s	Son	2940	Hernw	boot	Road	Wor	dstock	-Mar	vland	21	163	
Baltimore,	of He of He if Item		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 □Removal from	20b. F	Place of Disponentery, crei	nsition (Nam	ne of ther place		D	ate	20c. Lo	cation - City			
Ë	t. Pages riment of a rient: If it		4 □Donation 5 □ Other (Sp	ecify)	Par	klawn	Pa	rk	A	pr.1,	2006	Rock	ville,	.Mar	yland	
Ba	permit. Pages 1 and 2 should b Department of Health and Mente Important: If Item 27 is marked ent Injury or other treumatic e		21. Signature of Funeral Service L	o.		Fr	ancis	J.	Coll:	ins 1	uneral	Hom	e,Inc			
	ž ±		23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that	caused the deat	h. Do not ent	er the mode	vers	, such as	cardiac o	,W.,Si r respiratory ar	Lver rest,	Spri	TA	D 209 pproximate iterval Betv	•
	Physician		Immediate Cause (Final disease or condition		r Gastr	ointes	tinal	tra	ct bl	5aa					nset and D	
Page	/Medical Examiner		resulting in death)		(or as a conseq		CINCI	C.L.C.	<u> </u>	cca						
Ą	Si .	er	Secuentially list conditions if any, leading to immediate	D	e Renal		re					-		-		
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Нуро	volemic	shock										
760,	be executed sicien and burial-transit	I Ex	resulting in death) Last		(or as a conseq	uence of):										
ထ	icate be ex physicien s the buria	dical		d. Hypo	kalemia									-		
9 X C	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna							1 2	23d. Date of	delivery		
P.O. Box	e death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2 ∏ Feta nant at time of d		Ectopic pre Other (spe						Month	Da	ay Y	ear
	hat the de id by the a detached		9 ☐ Unknown Part II. Other significant condition	1		ulting in the u	nderking es	use ave	n in Part I		23a Did to	obacco II	se contribut	te to the	cause of d	eath?
Records,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burtal-transit	d by				and g ar tho a	indonying de	1030 9110					ZNo 3□			
S S S	aw require s been sig 2 should b	Completed									24a. Was		24b. Were	e autops)	y findings a	vailable
		Som										rmed?	death	h?	iletion of ca □ No	IUSO OF
Vita Vita	nding Physicien: Th th. : After this certificete funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	(Check only o		1			
ot	Phys rthis ral dir	- L	1 ☐ Yes 2 🗷 No 27. Manner of Death	1 123	Inpatient 2 of Injury	ER/Outpatier 28b. Time o			4 🗆 NU		ne 5 Resid			Specify)		
on	Attending Physicien: r death. ector: After this certific by the funeral director.	atior	1 XNatural 5 ☐ Pending 2 ☐ Accident investig		of Injury oth, Day Year)	Injusy	М	8c. Injury Work 1 □ Y	? /es 2 □!				,			
Division of Vital	_ 0	ertification;	3 Suicide 6 Could n 4 Homicide determine	nor 200. Place	of Injury - At ho	ome, farm, sti	eet, factory	, office		2	28f. Location (S City or Tox			r Rural R	Route Numi	ber,
Ω	pitel o	O	29a, Certifier 1X Certifying	Physician, To th	a boot of my kno		h coourad d	at the time	- 401- 00	d stage a	and due to the					
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	(Check only 2 Medical E	g Physician: To the examiner: On the be and man	asis of examina ner stated.	tion and/or in	vestigation,	in my op	e, date and inion, deat	th occurre	ed at the time,	date and	place, and	due to th	ed. ne cause(s)	
	To the within To the comp	ž	29b. Signature and title of certifier	110			29c	. License	number			29d. Date	e signed (M	Ionth, Da	y, Year)	
	1		. Sch	- NA		<u>.</u>	D5	50870	O			Marc	h 29,	200)6	
10	11		30. Name and address of person v Suzan Abdo,	who completed cau	•		•) מו	ark ar-	411~	MD 310	120				
	Sta	te	31. Date filed (Month, Day, Year)	320	Registrar's Signa	ture	, #ZUZ	-, C10	TTVDA	+ 116	, ETD ZIC	143				
	Registr	ar	MIHK 9 T	ZUUb	Registrar's Signa	T. Ago	SHE									

Certificate of Death

Specify:

For State Registra

Sidney

5. Social Security Number

065-16-8452

10a. State

MD

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

Decedent's Name (First, Middle, Last)
Sidnev S.

4a. Facility Name (If not institution, give street and number)

10b. County

Montgomery

Renaissance Gardens Assisted Living

1 XM 2 ☐ F

DeVries

92

7. Age (In yrs. last birthday)

10c. City, Town or Location

Silver Spring

State of Maryland / Department of Health and Mental Hygiene [] [] 2. Date of Death 3. Time of Death March 22, Day 2006 Year 3:04 A 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 8. Date of Birth July 134, Year 913 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 10d. Inside City Limits 1 Yes 2 XNo 10g. Citizen of What Country? United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. White 16b. Kind of Business/Industry Manufacturer 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Applebaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 St Andrews Lane Silver Spring MD 20901 20c. Location - City or Town, State March 26, 2006 Adelphi MD Danzansky-Goldberg Memorial Chapels Inc 6 Months 6 Mouths 6 Months 23d. Date of delivery Month Day Year

29d. Date signed (Month, Day, Year)

March 23, 2006

Ischemic Cardiomyopathy Coronary Artery Disease
Due to (or as a consequence of): 3 Ectopic pregnancy 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yeş 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28c, Injury at Work? 1 TYes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie (Check only and manner stated.

29c. License number

D0033475

State Registrar

5

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

carke

Dr Karen Merritt 3110 Gracefield Road Silver Spring MD 20904

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2 2006 3:45 P^M Robert L. Dawson April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□ F Yrs. Director 579 12 1833 91 Jan 19, 1915 Virginia Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "netural", or items 23s or 28s-f show other traumatic event, the Madical Experiment must be excitited at 1 Yes 2 No Director MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 United States 6411 Hickory Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Machinist Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be 1eeith and Mental William B. Dawson Lavinia Danson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a important: if item 27 is any injury or other trau 6601 Seneca Farm Road Columbia, MD 21046 Stephen Dawson/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Good Shepherd Cemetery 4-5-2006 Ellicott City, MD 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 0 W 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) your kalema **Physician** /Medical Due to (or as a consequ ence of) Examiner Kera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death signed by the e 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Bleed certificate 1□ Yes 2 1No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours efter To the Funeral Dire 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) East Main St. Westwinster MD 21157. MO torain 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 03 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2006 7:40 P 10, Escobar April /Medical Marguerite 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mt. Airy

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Kline Hospice House 7. Age (In yrs. last birthday) 85 yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Ohio Director 283-18-7090 28, 1921 Feb. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f ahov the Modical Examiner must be notified at Harford Aberdeen 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 834 Lynn Lee Drive 21001 U.S.A. death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. e tiled within 72 hours after all Hygiene.

Other than "natural", or Ital 1 □Yes 212 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 312 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 la marked other tt any Injury or other traumatic avent, Iba once. 12 Homemaker In home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be August Brewster Emma Cunaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Escobar (Son) 518 Glenbrook Dr. Middletown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Donation 5 ☐ Other (Specify) Harford Mem. Gdns. 4/13/06 Aberdeen, Maryland 22. Name and Address of Facility
Tarring-Cargo Funeral
Aberdeen, Maryland 21. Signature of Funeral Service Licenses WHEN 23a. Part1. Enter the disease, or complications that consed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENDOMETRIAL **Physician** CANCER 4 YFARS /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physiclen end the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cete has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → Yo 24a. Was an certificete has autopsy perform 1 Yes 2 XNo or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) IN PATIENT HO 1 Yes 2 No 2 ER/Outpatient ဥ 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: icE. 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11 H APRIL, 2006 56314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21702 46 B THOMAS JOHNSON PREDERICK DRIVE, BINDU GEORGE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 4 2006

		1	For State Registrar	State of Ma		artment of F			Reg. No.UUD	1810
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month March 2	Day Year	3. Time of Death
	Physicia /Medic	al .	Marion R. Eggers							4:02 P M
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, o	r Location of E	Death	4c. County of Dea	
6.5		. 3	Montgomery General 5. Social Security Number 6. Sex		L (In yrs. last birthday)	Olney If Under 1 Year	If Under 24		h 9. Bir	thplace (State or Foreign
40.8	Funeral Director			M 23F	92 Yrs.	Months Days	Hours	Min. (Month, Day May 29		ountry) orth Dakota
	P .	-	Usual Residence of Decedent		10c. City, Town or L	ocation				10d. Inside City Limits
	ahow		10a. State 10b. County Maryland Montgome		Wheaton	ocation				1 ☐ Yes 2 No
	the M	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	3a or	급	12204 Edgemont St	eet		209	02		USA	
92	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mantel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Modical Exercited must be notified at	y Funeral Director	1 ☐ Never Married 2 ☐ Married	2. Was Decedent E Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No.} \) If Yes, Give	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whi Specify: Who	te, etc.
21215-0036	hours turet',	d by	3 [™] Widowed 4 Divorced	Year or Dates:	16a Dece	edent's Usual Occup	pation		16b. Kind of Business	/industry
7	in 72	ojete	(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most o d)	f working		,
212	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	Hor	nemaker			Own Home	е
pu	al Hyg	Bec	17. Father's Name (First, Middle, Last)				_	s Name (First, Middle,	Maiden Sumame)	
Maryland	Mant Mant arkec	2	Oscar Ranberg					na Johnson	City or Town State	Zin Codol
Mar	12 short and resum		19a. Informant's Name/Relationship (Type Susan E. Webb/Daugh			-			er, City or Town, State, Spring, MD	
e)	1 and Haaiti am 27		20a. Method of Disposition		20b. Place of Disp	osition (Name of	1	Date	20c. Location - City of	
nor	Pagas nant of I nt: if its iry or o		1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State		matory or other pla emorial Parl		arch 31, 2006	Rockville,	Maruland
Baltimore,	parmit. Pagas Dapartmant of himportant: if ite any injury or of once.		21. Signature of Funeral Service License	е	9	Trancard Addre	ss of agily	ins Funera	1 Home Inc.	
	* *		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do not er	nter the mode of dy	ng, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	Hemm	norhagia	e Basa	l Go	malia In	farct	Onset and Death 4 days
ģ.	/Medical		resulting in death)	Due to (or as a	consequence of)				,	1
0.	Examiner	_	Sequentially list conditions, b	Due to for as a	consequence of):					
	ad sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or).					
_6	ita ba exacutad ysician and ne burial-transit	хаг	that initiated events c resulting in death) Last	Due to (or as a	consequence of):					
760,	ta ba e) ysician ne buria	cai	€ d							
68										
.O. Box	The law requires that the death certificat tie has been signed by the attending phy page. 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify) _	ey		23d. Date of de Month	elivery Day Year
Δ.	uiras that the signed by do datad	þ	Part II. Other significant conditions con	tributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.	23e. Did t	obacco use contribute Yes 2 DNo 3 DF	to the cause of death? Probably 4 □Unknown
Records,	The law require	Completed						24a. Was auto perfe	psy prior to death?	autopsy findings available completion of cause of
Vital	sician: Th cartificate ractor, pag	BeC	25. Was case referred to medical examiner?					of Death (Check only	one)	
of V	Physician: this cartificral diractor.	မ	1 ☐ Yes 2 ☑ No	ospital: 1 Thpatie		ent 3L DOA			dence 6 Other (Sp	pecify)
	ng fta/	io io	27. Manner of Death 1	28a. Date of Injur (Month, Day	y Year) 28b. Time Injury	Wo	iryat ork?]Yes 2.∐N		now argury occurred	
Division	i or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At home, farm, s c. (Specify)			28f. Location	Street and Number or i wn, State)	Rural Route Number,
	Hospita 4 hours Funarai ely fillac	edical Co	(Check only 2 Medical Examinations)	ner: On the basis of and manner sta	examination and/or ted.	investigation, in my	opinion, death	h occurred at the time,	cause(s) and manner date and place, and d	ue to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title o certifier			29c. Licer	nse number		29d. Date signed (Mo.	nth, Day, Year)
	C > E 0		Slan	DHV	CICIAN	J DGS	3/68	3	3/20/	06
	6		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Typ	e, Print)	ad: a	al CLI/ T	VPNL	ALL OILL
_	<i>\(\varphi\)</i>		SHYAM M PAR	KHIE.	MO 4	JOI M	KUI CC	M GIV 1	1.11CUC	VILLETIVID
A.	St Regist	ate rar	30. Name and address of person who co	32. Aegistra	ar's Signature	foods				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4a. Facility Name (If not institution, give street and number) 1115 PM MES 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimete a Center Hayland Shock Traum 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** M 2□F 49 Hours 202-48-3931 Work, PA Director March 13,1957 Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If itsm 27 is marked other than "natural", or items 23e or 28a-f show any hjury or other traumatic avent, ite Madical Examiner is used to notified as once. Monteomery 1 Yes 2 No Completed by Funeral Director Dicker son 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24801 White's Ferry Rd. USA 20842 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2. Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager terry boat 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pfleiger) Patricia Garey L. 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24801 White's Ferry Rd., Dicker som, MD 20b. Place of Disposition (Name of cametery, crematory or other place)

Susqueherma Memorial Gardens April 3, 2006 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Koller Funeral Home, Inc. M00696 2000 W. Market 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Head WEEK Injuites /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, 23c. If yes, outcome of pregnancy. (1) Live birth 2 ☐ Fetal death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by None 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1□ Yes 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2 No 2 ER/Outpatient 3 DOA After this funeral dir 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Tree Branch Struck heid death. 1 Nes 2 No 2 Accident Mos 14 2006 1200 PM within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dick- sen Piercation 24801 Whites Feiry Romai 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 416535 April 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registr<u>ar</u> Felix

31. Date filed (Month, Day, Year)

Luci

APR 1 4 2006

S. Circene Street

2. Registrar's Signature

Bultimore

			1 - For State Registrar	State of M	aryland		artment <i>tificate</i>			and Me	ental Hy	ygieņ		6	118	12
	Physici /Medic		1. Decedent's Name <i>(First, Middle, La:</i> Bery1	Forsen							2. Date of D Month MARCH	Da	2006	Year	3. Time of 1:35	
	Examin		4a. Facility Name (If not institution, give COLLINGSWOOD NURS)	ING HOME				RO	Location o	LE		40	c. County o		GOMERY	
	Funeral Director	d.	5. Social Security Number 6. S 042-20-7896 Usual Residence of Decedent	ex 7. Ag ☐ M 2 ☐ NF	92	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, D)4/01/	ay, Year,	,	Cour	place (State of htry) YORK	or Foreign
	the Maryland r 28a-f show	rector	10a. State 10b. County	rgomery	10c. City,	Town or Lo		Code	C			10g. Ci	tizen of W			ity Limits 2 🗌 No
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show emportant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show employing or other traumatic event, the Medical Eventual retributed at angles.	by Funer	8138 INVERNESS RII 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces: 1Yes 2X If Yes, Give Year or Dates:	?	1	Was Decede f Yes, speci	ent of Hi rfy Cuba		gin? (Spec , Puerto P	ofy Yes or Nican, etc.)	lo-	14. Race	, White,	an Indian, etc.	
Maryland 21215-0036	e filed within 72 h il Hygiene. other then "netu vent, Ine Medice.	e Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	de completed) College (1-4or	5+)	(Give	dent's Usual kind of word DO NOT usi	k done d e retired,	furing most		g (First, Middl			ELEPI		
ylar	Menta	To B	CHARLES HENRY POST								NA WOE					
	1 and 2 sh Health and em 27 is n ther traum		19a. Informant's Name/Relationship (CEORGE FORSEN/SON 20a. Method of Disposition	Гурв, Print)	20b. Pla		INVER	RNES			Poute Num. DAD, P	OTOM		ID 2	20854	
Baltimore,	t. Pages rtment of I rtant: If Its		1 Burial 2 Cremation 3 4 Donation 5 Other (Specification of Fundamental Secretary)	()	cer	netery, crer IONAL	CREMA	TOR	LUM 0:	3/29/					H, VIR	GINIA
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198	Physician /Medical Examiner	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	a. ATRIAL Due to (or as b. DEEP VE Due to (or as c. DEMENTI	FIRBR a conseque IN THI	ILLAT ence of): ROMBOS	ON								Interval Bet Onset and	tween
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S, D	4 be de	þ	Part II. Other significant conditions o	ontributing to death t	out not result	ting in the u	nderlying ca	use give	en in Part I.			tobacco		bute to th	ne cause of c	death?
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	ysician: Th is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2□E	R/Outpatier	t 3 DO	A Othe	r		(Check only e 5 ⊟ Res		6 □Othei	(Specifi	v)	
Division of	Attending Physician: r death. sctor: After this certific by the funeral director,	ertification: 7	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not bi		ay Year)	28b. Time of Injury	M 28	Bc. Injury Work	at ? /es 2 🗆 N		8d. Describe	how inju	iry occurre	d		
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	the Hospital hin 24 hours the Funaral hpletely filled	edical	29a. Certifier 1 ☑ Certifying Ph (Check only 2 ☐ Medical Exan one)	ysician: To the best niner: On the basis of and manner st	of examination	ledge, deatl on and/or in	occurred a vestigation,	it the tim in my op	e, date and pinion, deat	d place, ar th occurre	nd due to the d at the time	e cause(s e, date an	i) and man d place, ar	ner as si	tated. the cause(s	s)
)	To the within 2 To the complete	Me	29b. Signature and title of certifier	M.D			29c.)3013	2			ate signed ARCH		Day, Year) 2006	
_	6		30. Name and address of person who M. RITA &HOSH, MD					ITE	221,	ROCK	VILLE	, MA	RYLAN	D 2	20850	
4	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1	32. Regist	rar's Signatu	ire	oest!	,								

06-02134 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Paula Marie Flathman State of Maryland / Department of Health and Mental Hygiene RJD Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Flathman **Physician** Paula Marie March 27, 2006 0815 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Bound 425 South of Bicknell Rd. Charles Pisgah 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1 ☐ M 2 💢 F April 29,1972 WashingtonDC Director 219-13-7546 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County •how ir then "naturel", or Iteme 23a or 28a-f ehovithe Mudical Examinar must be notified at 1 Yes 2 No Indian Head MD Charles Directo 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 20640 USA 5810 Smallwood Church Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 12 other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other eny injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Randall Scott Wilmoth Sharon Ann Wilmoth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6948 Glasgow Lane, PortTobacco, MD 20677 Randall Wilmoth/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Sacred Heart Cemetery 4/6/06 La Plata, Maryland M00945 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567, LA PLATA, MD 20646

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple injuries **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9X Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

↑ Yes 2□ No 24a. Was an autopsy performed? 2□ No Yes 2□No certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) (Iniury at 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No ၉ 2 ER/Outpatient 3 DOA scene this : After the 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: s after dec. 1 Natural 5 Pending 1 ☐ Yes 2 ➡No Driver in auto/auto collision investigation 2 XAccident 3-27**-**06 8:10a 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Road

N/B 425 so. of Bicknell Rd

To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Road

N/B 425 so. of Bicknell Rd

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. ö To the Hospital within 24 hours a To the Funerel D 29a. Certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) MAR 3 1 2006

29b. Signature and

te of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

O.C.M.E.

March 28, 2006

111 Penn Street, Baltimore Maryland 21201

				partment of Health and Mertificate of Death		iene 006	1814
ı	Dhysisi	20	Decedent's Name (First, Middle, Last)		2. Date of Deal Month	h Day Year	3. Time of Death
	Physici /Medio		ROBERT JAMES GOURLEY		APRIL	10 2006	3:00p ^M
5	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			106 Cedarwood Dr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Galena V) If Under 1 Year If Under 24 Hrs.	D. Data of Righ	Kent	5-1 (2) - 5
¢	Funeral Director		194-20-7091 1½M 2□F 78 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Nov 21	Year) Co	thplace (State or Foreign ountry) nnsylvania
			Usual Residence of Decedent		NOV 21	1327 101	mbyivania
	show	بد	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	88-10	scto	MD Kent Galena				1 X Yes 2 □ No
	death with the Maryland ms 23a or 28e-f show rmust be notified at	Funeral Director	10c. Street and Number	10f. Zip Code		0g. Citizen of What Co	ountry?
	eath	erai	106 Cedarwood Dr. 11. Marital Status 12. Was Decedent Ever in U.S. 13	21635		U.S.A.	nican Indian
_		표	1 Never Married 2 Married Armed Forces? 1 No 1946 1 Yes, Give	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
12-003b	within 72 hours after deat ene. then "naturel", or items ? fre Medical Examiner mu	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: -1948	1 ☐ Yes 2 1 No Specify:		Specify: W	hite
2	d within 72 ho piene. r than "natur r e Modical	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of work	cina	16b. Kind of Business	/Industry
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Z	filed v Hygie other t		17. Father's Name (First, Middle, Last)	il Engineer 18. Mother's Nam	o (First Middle A	Transpor	tation
and	ed all all	Be c	Robert Frank Gourley		Techto		
5	s 1 and 2 should be f Health and Mental ftem 27 is marked other treumatic ev	2		ling Address (Street and Number or Rus			Zin Code)
Z	5 = 7 = 1			6 Cedarwood Dr.			
<u>ရ</u> ် -	is 1 and 1 a		20a. Method of Disposition 20b. Place of Dis			20c. Location - City or	
Ē	Page nent o int: If		I Li bunat 2 Ki Cremation 3 Li Hemoval from State		1/06	Smyrna,	DE.
Baltimor	permit. Pages. Department of the importent: If ite any injury or of once.			22. Name and Address of Facility Galena Funeral 118 West Cross other the mode of dying such as cardiac	St. Gal	ena, MD.	L Schaech 21635 Approximate
	Dhamistan		shock, or heart failure. List only one cause on each line.	4	or roophatory arre	,	Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of):	lymphoma			3 weeks
	Examiner		D- 10 . 0 . 2'a				3 needs &
,	n =	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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cords,	w requires that the de been signed by the a should be detached t	sted by	Science disorder, Posthopetic r MTN, renal stones, meningion		1 🗆 Ye	s 2⊡No 3□Pr	
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N I G	Physician: this certific al director,	o Be	25. Was case referred to medical examiner?	26. Place of Deat			
5	this alo	Η.	27. Manner of Death 28a. Date of Injury 28b. Time	ent 3 DOA 4 Nursing Ho	28d. Describe ho	nce 6 Other (Spec w injury occurred	cify)
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DIVISION	Atter r dea ector by the	Certification;	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	treet, factory, office	28f. Location (Str	reet and Number or Ru	ıral Route Number,
5	s afte si Dir	Cert	4 Homicide building, etc. (Specify)		City or Town	, State)	
	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certific completely tilled in by the funeral director,	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the best of the best of my knowledge, deal of the best of the best of my knowledge, deal of the best of th	ath occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	Vith To t	Σ	29b. Signature and title of certifier	29c. License number	_	d. Date signed (Monti	h. Day, Year)
			MO MO	D5173	>	4/11/2	
-	641		30. Name and address of person who completed cause of death (Item 23a) (Type				
	CA	10	Frederick Delboy, M.D. 6602 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Church Hill Rd	. Chest	ertown,	MD. 21620
	Sta Registr		APR 1 4 2006 Region # Apr	de la company de			

			For	State of Maryland / Department			2000	11015
			State Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Death	2. Date of De		3. Time of Death
	Physicia /Medic	an		ank Golder		Month -	10-200C	3:30Pm
	Examin		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of D	Death	4c. County of Deat	h
	C		Devlin Manor Nursi 5. Social Security Number 6. Sex		Cumberland ff Under 1 Year If Under 24	Hrs. 8. Date of Birt	Allegany	hplace (State or Foreign
	Funeral Director			M 2□F 89 Yrs.	Months Days Hours	Jun 13	, 1916 P	intry)
	land ow II		Usuaf Residence of Decedent 10a, State 10b, County	10c. City, Town or L				10d. Inside City Limits
	a-fah	ctor	MD Allegany	y Cum	berland			1 □XYes 2 □ No
	with the	Dire	10e. Street and Number 10301 Christie Roa	d	10f. Zip Code 21502		10g. Citizen of What Co	untry?
	death ma 23	Funeral Director		12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No		
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or itama 23e or 28a-f ahow avent, the Medical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Xidowed 4 Divorced	Amed Forces? 1	1 ☐ Yes 2 No Specify:	deno moan, etc.)	Specify: wh	-
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Maryland 21215-0036	be filectal Hyg d otherwart,	Bec	17. Father's Name (First, Middle, Last)			Name (First, Middle, e Perry Go		
ryla	hould id Men marke matic	ဥ	Ed Golder 19a. Informant's Name/Relationship (Ty)	pe, Print) 19b. Maif	ing Address (Street and Number of	or Rural Route Numb	er, City or Town, State, .	Zip Code)
	and 2 selth er 27 ia er trau		Carla Taylor		. Box 414		Ashby	WV 26719
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic avant, the Medical Exemplating must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Termation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of ematory or other place) uneral Home, P.A.	Date 4/11/2006	20c. Location - City or Cresaptow	
Balt	Departimonts in ports		21. Signature of Funeral Service Licens	The MANA 2	22. Name and Address of Facility Scarpelli Funera			.0
_	10144		23a/Part1. Enter the disease, or compli	ications that caused the death. Do not en	108 Virginia Ave	nue; Cumbe irdiac or respiratory a	rland, MD 2150 rrest,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Cere bro Vascula	Academl-			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
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9	rtificate ng phy: as the	0	TE SEMALE.					
Box	ie deeth certificatha attending planed for use as t	Physician/M	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	fivery Day Year
P.O.	The law requires thet the de ate has been signed by tha bage 2 should be detached		9 ☐ Unknown Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute t	the cause of death?
rds,	n signe	d by	Corbbay an	tery disease		10	Yes 2.DNo 3□P	robably 4 DUnknown
Vital Records,	ne faw requir has been si ge 2 should i	Completed				24a. Was	an 24b. Were a	utopsy findings available completion of cause of
a R						1 ☐ Yes	ormed? death? 2☐No 1☐Ye	2 □ No
Ž	Physician: this certifical	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	I -	of Death (Check only sing Home 5 ☐ Res	one) idence 6 Other (Spe	ocify)
n of		on: T	27. Manner of Death 1. ■ Matural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work?	28d. Describe	how injury occurred	
Division	deat deat tor: / the	licati	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s	M 1 ☐ Yes 2 ☐ No	28f. Location	(Street and Number or R	ural Route Number,
Ω	s efter is ofter in Dire	Certification;	4 Homicide	building, etc. (Specify)		City or To	wn, State)	
	To the Hospitel or At within 24 hours efter of To the Funeral Direct completely filled in by	edicai (25a. Certifier 12. Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, der iner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and investigation, in my opinion, death	place, and due to the occurred at the time,	, date and place, and du	e to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier		29c. License number	27	29d. Date signed (Mon	•
	0		30 Name and address of ourse who are	ompleted cause of death (Item 23a) (Type	Dou 3328		4/21/	- 00 0
	<u>ک</u>		Sunil Gunta M.D.	625	Kent Avenue Cur	mberland M	1D 21502	1
	St. Regist	ate	Sunil Gupta M.D. 31. Date filed (Month, Day, Year)	32. Registrar's Signature	1. 16.8			
	HMH 17 Bay 1/		HFR 1 4 2	UUD Brief St. A				

DHMH 17 Rev 1/2001

Please Type	e or	Print in	Black	Indelible I	nk.	Ensure	AII	Copies	Are	Legible
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		For State	State of Maryland /	Departme					(Co	11016
		Registrar 1. Decedent's Name (First, Middle, Last)		Certific	ale of L	/eatii	2. Date of Death	J. Nò.		3. Time of Death
Physic /Med		Francisco Martins	Goncalves					29, 200	Cear O	2:20 a M
Exam		4a. Facility Name (If not institution, give st. Suburban Hospita			ity, Town, or Bethes	Location of Death đa		4c. County o		gomery
Funera Directo	_	5. Social Security Number 6. Sex 15	7. Age (In yrs. last b	rirthday) If Ur Mont	hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 12	Year) 1958	Coun	lace (State or Foreign try) rtugal
Maryland -f show	tor	Usual Residence of Decedent		wn or Location		-			11	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
or 28a	Director	10e. Street and Number			Zip Code	0	10	g. Citizen of W	hat Coun	
deeth w me 23e	Funeral	18507 Denhigh Circ	2. Was Decedent Ever in U.S.	13. Was De	2083	spanic Origin? (Spent, Mexican, Puerto	acify Yes or No-	14. Race		an Indian,
urs after only, or the	by Fur	3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		s 250 No	Specify:		Specify:	T.11.	ite
partitioning in the property of the control of the partition of the pages that a should be tiled within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. I importent: If them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercities must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		life. DO NO	f work done d T use retired;	uring most of work	ing	6b. Kind of Bus Constru		
il Hygier other th	Be Co			Forema	.11	18. Mother's Name				
ylating louid be filt Mental Hi harked oth	ToB	Antonio Martins (Oh Mailing Add	ross (Stroot a	Ana V	az Marti		State. Zir.	Code)
INICAL Ind 2 sh alth and 127 is m		19a. Informant's Name/Relationship (Type Maria Amelia Gonca				Circle,	Olney,	Marylan	đ 20	832
in itan	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	of Disposition tery, crematory	or other place	a) Apri	1 3.	ilver S		own, State ng, Marylan
Dallillor permit. Pages Department of importent: if it	ence.	4 Donation 5 DOther (Specify)		T-44-344.	ra arro vocios	aroffedity n s	Funeral	Home In		MD 20901
Physicia		23a. Parl. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	o not enter the	mode of dying	g, such as cardiac	or respiratory arre	st,		Approximate Interval Between Onset and Death 6 Months
Physicia /Medica Examine	al	disease or condition resulting in death)	Lymphoma Due to (or as a consequence	ce of):						o riolitetto
ted nsit	Examiner	Sequentially list conditions, it my, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):						
OX OS/OU, certificate be executed ading physicien and use as the burial-transit	Heal Exa	that initiated events cresulting in death) Last	Due to (or as a consequence	ce of):						
OO/ ifficate g phys	1									
death death e atter	Ohvelclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		oic pregnancy or (specify)			23d. Date Mor		ery Day Year
dS, F.	1	Part II. Other signmeant conditions con	tributing to death but not resultin	g in the underly	ing cause give	en in Part I.	1			the cause of death?
of VITAL HECOTIS, F.O. hysicien: The law requires that the his certificate hes been signed by the director, page 2 should be detached.	potelomo						24a. Was a autops perform	y ned?	rior to co leath?	opsy findings available ompletion of cause of
tor. F	9	25. Was case referred to medical				26. Place of Dea	th Check only on	θ/		
OT V Physic this ce al direc	F			Outpatient 3[DOA Oth	4 Nursing H	ome 5 Reside			(y)
On C			28a. Date of Injury (Month, Day Year) 28	b. Time of Injury M	28c. Injur Wor 1	yat k? Yes 2 ∐No	28d. Describe ho	w injury occurr	∌d	
Division of Vital tor Attending Physicien: 1 after death. Director: After this certificel in by the funeral director, p	, de colsista	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fa	actory, office		281. Location (Si City or Town		er or Rur	ral Route Number,
DIVISION To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a Certifier tf Certifying Phys	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death occi and/or investig	urred at the till pation, in my c	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and ma ate and place, a	nner as : and due	stated. to the cause(s)
To the vithin 2 To the comple		29b. Signature and title of certifier	()		29c. Licens D	se number 51616	ż	9d. Date signed Marc		, Day, Year) 9, 2006
12		30. Name and address of person who con Nelson Kalil, M.		Ba) (Type, Print)	enue,	#1300, Cl	nevy Chas	se, MD 2	2081	5
	State istra	31. Date filed (Month, Day, Year)	32. degistrar's Signature	Cher	r e					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:34 P M 19, MARCH 2006 LIMA GONZALES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES CHEVERLY GLADYS SPELLMAN NURSING HOME 8. Date of Birth (Month, Day, Year) FEB. 12, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1□M 2X)F 1927 TRINIDAD, 79 Director 217-45-2350 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r iteme 23a or 28a-f show 1 Yes 2 No Director PRINCE GEORGES RIVERDALE MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20737 TRINIDAD 4800 LONGFELLOW ST. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify: Specify: If Yes, Give Year or Dates: other than "naturel", c 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOME 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Pages 1 and 2 should be PETRA VIRUEL LOUIS GONZALES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health sitem 27 i 4800 LONGFELLOW ST., RIVERDALE, MD. 20737 CHIMMING/DAUGHTER MARGRETE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 13-25-2006 CHAMBERS CREMATORY RIVERDALE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Licenses **4** мооо91 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 5 MONTHS RENAL CELL CARCINOMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off. Examine or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events nding physician and resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4X Unknown RESPIRATORY FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an RENAL FAILURE autopsy performed? Yes 20 No certificete 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 ☐ Yes 2 ▼No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney-glated. (Check only one) ro the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title MD 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6130 LANDOVER RD., CHEVERLY, MD. 20785 MURTHY, M.D. REVATHY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Consult. MAR 2 2006 Registrar

			For State Registrar	State of Maryland		rtment tificate			Mental Hy	giene Reg. No.) 6	8
		The second	Decedent's Name (First, Middle, Last)						2. Date of Di	eath Day	Year	3. Time of Death
	Physicia /Medic		NATHAN CONANT C	ARNER					March	22	2006	9:44 A M
	Examin	1, 75	4a. Facility Name (If not institution, give str					ocation of De	ath		ity of Death	
ŤĚ			Montgomery General			01r					itgome	
22-	Funeral Director		010.32.9200	7. Age (<i>In yr</i> s. <i>Ia</i>	Yrs.	If Under 1 Months	Days	If Under 24 H Hours M		nth ay, Year) 1941	9. Birthp Cour Verm	lace (State or Foreign ntry) ont
	and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	daryli f eho	ō	Maryland Montgomer	y Si	lver	Spring	5					1⊠Yes 2□No
	28s	Directo	10e. Street and Number			10f. Zip C	Code			10g. Citizen o	f What Cour	ntry?
	death with the Maryland me 23a or 28a-f ehow must be roll fied at		433 St. Lawrence D	rive		20	901			U.S.	Α.	
	be filed within 72 hours after death with the Marylar Hygiene. All Hygiene. All Hygiene. All Cherthan "natural", or Iteme 23a or 28a-f ehow other than "natural", or Iteme 23a or 28a-f ehow event, the Madical Exprintat must be collised at	Funeral	Tr. Maria Clares	2. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Was Decede f Yes, specif	nt of His y Cuban	panic Origin? , Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0- 14. R	ace - Americ lack, White,	
50	hours after tural', or ite	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 21X No If Yes, Give Year or Dates:		1 □ Yes 2	No No	Specify:		Spec	city: Whit	e
21215-0036	2 hou		15. Decedent's Educa	ation	16a. Deced	dent's Usual	Occupat	ion iring most of v	working	16b. Kind of	Business/In	dustry
7	e filed within 72 h al Hygiene. i other then "natu vent, the Medical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use	retired)	mig most or r	·onang			ington Univ eatre/Dance
	ed wi ygien yer th	Co		5+	Proi	essor		O Mathada N	lana (Fire t thirdel	-		eacre/ bance
/land		To Be	17. Father's Name (First, Middle, Last) William Chadwick	c Garner				Edith	Name (First, Middle Harris	e, maigen suin	ame)	
	s 1 and 2 should f Health and Men ltem 27 is marke other traumatic	۲	19a. Informant's Name/Relationship (Type	e, Print)					Rurai Route Numi	-		1.6
, mar	s 1 and 2 if Health a item 27 is other tra		Victoria W. Garner					ce Driv	ve, Silve			
e G	m O +		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re	CA	ace of Dispo	natory or oth	er place)	Date	20c. Locatio	-	
Ĕ	Pages ment of ant: If It ury or o		4 □Donation 5 □Other (Specify)	A Ft.					/24/2006			
Baltimore,	permit. Pages Department of Important: If It any injury or o		21. Signature of Funeral Service Licensee	+	22							HOME, INC. ing,MD 20904
	40 = 40		Maning A . The	ations that caused the death	Do not ont						I SPI	Approximate
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	. 50 1101 6111	.01 1110 110 00	or 07.11g	, 500.7 40 54.7				Interval Between Onset and Death
2	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	(A)							5 DAYS
	Examiner		Î	Due to (or as a consequ	erice ory.							
(d)		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequ	ence of):							
	ocuted nd transil	Examiner	Cause (Disease or injury that initiated events c.									
760,	ite be executed sysicien and he burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):							
6876	physic the p	dical	d.									
9 XO	eath certific attending p	/Me	IF FEMALE: 23	c. If yes, outcome of pregnar	псу					23d. I	Date of deliv	erv
m	death a atter d for u	Iclar	23b. Was decedent pregnant in the past 12 months? 1 \sum Yes 2 \sum No	1 Live birth 2 Fetal 4 Pregnant at time of de		∃Ectopic pre ∃ Other (<i>spe</i>		<u>.</u>			Month	Day Year
л О	The law requires that the death certifica ate has been signed by the attending ph page 2 should be delached for use as th	Physician/Med	9 Unknown	9□ Unknown					00 Pid		7	h
	res that igned b	by	Part II. Other significant conditions cont	_	-		-		1			he cause of death? Dably 4 DUnknown
o C	w require been sig	eted	ADU-T RESPIRATOR	1					-			
Records,	e law has b je 2 s	Completed	RESPIRATORY FAILU	re nute re	MAL F	ALLUR	-E			s an 24 opsy formed?	prior to co death?	opsy findings available empletion of cause of
a	sician: The law s certificate has t Irrector, page 2 s		DISSEMINATED INTRA	RIEM DISEA	neuch	BD0™			1 ☐ Yes	2 XN 0	1 🗆 Yes	20 NO NA
Viital	Physician: r this certifica ral director, I	o Be		ospital:		nt 3 🗆 DO	_		Death <i>Check</i> o <i>nly</i> g Home 5 ☐ Re		Other (Speci	6v)
ō	Phy this	H- 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28	lc. Injury Work	at		how injury occ		
<u>o</u>	Attending or death. ector: After by the fune	ation	1 Accident 5 ☐ Pending investigation	(Month, Day Fear)	Injury	м		es 2□No				
Division	or Attendate deat Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory,	office		28f. Location City or T	(Street and Nu own, State)	mber or Run	al Route Number,
	oltal or urs afte sral Dir illed in	Cel	00-0-47-	sion. To the board of	ulade - 1	4	a the e	a data a : 1 ·		0.0000000000000000000000000000000000000	manager	Noted
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		cian: To the best of my known: On the basis of examinat and manner stated.								
	To th within To th	₩ W	29b. Signature and title of certifier			29c.	License	number		29d. Date sig		•
-			Dr. Lilux Meine	- Howatini	,	Di	0058	542		MARCH	22, 20	06
	20		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type,	Print) GEURG	iA.	AVEHUE	三 片 515	WHEAT	א ענ	0 20902
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 7 20	32. Begistrar's Signal	ture	barle						

		of Maryland / Department of Health I,25,27,28a-f par MF, 382,12/07/01		11819
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) Mich O-P Facility Name (If not institution, give street and n	Caril number) 4b. City, Town, or Location	2. Date of Death Month Day Year March 23 2006 of Death 4c. County of Death	3. Time of Death
Funeral Director	no Johns Hopkins Social Security Number 69-56-6951 Ual Residence of Decedent		or 24 Hrs. 8. Date of Birth 9. Birth	nplace (State or Foreign untry) D
ith the Maryland or 28a-f ehow be motified at	a. State 10b. County L Palm Beach e. Street and Number	10c. City, Town or Location Delray Beach 10f. Zip Code	10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ▼ No untry?
ltems 23a	754 Casa Grande Way Marital Status 12. Was De Armed	33446 accedent Ever in U.S. Forces? s 2 ∑No Character of Hispanic C If Yes, specify Cuban, Mexic Toltes: 13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic Specification 1 □ Yes 2 ∑No Specification	y: Specify:	ncan Indian,
	15. Decedent's Education (Specify only highest grade complete) Elementary/Secondary (0·12) College 4	Administrator	Charity	Industry
Maryland 2 Ind 2 should be filed If and Mental Hygis If the marked other traumatic event, I	Father's Name (First, Middle, Last) Bernard Garil 9a. Informant's Name/Relationship (Type, Print)	Etho	cher's Name (First, Middle, Maiden Surname) e 1 Goodman aber or Rural Route Number, City or Town, State, 2	
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then inportant: other traumatic event, training or other traumatic event, training.	Sernard Garil (Father) a Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cametery, crematory or other place)	Date Date	Town, State
Baltin permit. Departm importa eny inju	Signature of Funeral Service Licensee Annual Service Licensee Annual Service Licensee Annual Service Licensee		berg Memorial Chapels I	
Physician /Medical Examiner	nmediate Cause (Final isease or condition southing in death)	Anoxic Encepha	lopathy ost.ic Procedure	Onset and Death
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The cords, P.O. Box 687. The law requires that the deeth certificate the has been signed by the attending physicage 2 should be detached for use as the law physicago 2 should be detached for use as the law physicago 2 should be detached by Dhysician Madical Control of the law physician Madical Control of the law physician with the law physici	in the past 12 months?	outcome of pregnancy re birth 2 Fetal death 3 Ectopic pregnancy egnant at time of death 5 Other (specify) nknown	23d. Date of de Month	olivery Day Year
cords, P	Bleeding; Childhood Acute Le	o death but not resulfing in the underlying cause given in Pa L Carcinona; Upper Castrointest in Eukemia; Renal Failure status post	24a Was an 24b Were a	robably 4 Unknown
f Vital Record sysician: The law requir is certificate has been si director, page 2 should	Renal Transplant; Drug Ind.	26. Pl	performed? death? 1 Yes 2 No 1 Yes ace of Death (Check only one)	s 2□ No
Division of Vital Records, To the Hospital or Attending Physician: The law requires twithin 24 hours after death. To the Funeral Director: After this certificate has been significantly filled in by the funeral director; page 2 should be	77. Manner of Death Natural S Pending (A Z Accident investigation Marci	Inpatient 2 ER/Outpatient 3 DOA A	281. Location (Street and Number or F	ollowing Bural Route Number,
Di no 24 hours aff he Funeral Di pletely filled in	29a. Certifier (Check only 2 Medical Examiner: On the	b the best of my knowledge, death occurred at the time, date to basis of examination and/or investigation, in my opinion, manner stated.	death occurred at the time, date and place, and du	as stated. ue to the cause(s)
	29b. Signature and little of certifier M D 30. Name and address of person who completed a	29c. License numb RES - C cause of death (Item 23a) (Type, Print)		
Stat Registra			600 North Wolfe Steet	21287

			_ TOI	partment of Health and Mental Hy	/giene
			Decedent's Name (First, Middle, Last)	2. Date of D	eath 3. Time of Death
	Physicia	_	MARI KORQEES HANA	Month APRIL	2, 2006 3:50AM M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	_ Admin	Ŭ.	8511 PERTH LANE	CLINTON	PRINCE GEORGE'S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs. 8. Date of Bi	irth 9 Birtholace (State or Foreign
	Director		218-45-6404 ^{1□M 2} F 81 Yrs.	Months Days Hours Min. (Month, D JAN. 1	, 1925 BAGHDAD
	p		Usual Residence of Decedent		
	show	<u>_</u>	10a. State 10b. County 10c. City, Town or I	Location	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	8e-1	ct		NTON	1 165 2Д110
	or 2	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	be filed within 72 hours after death with the Marylend tial Hygiene od other than "natural", or Itame 23a or 28e-f show event, I're Madical Examinal meat te modified at	ra E	8511 PERTH LANE	20735	U.S.A.
	ar de tame	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.
36	s afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 ☐ Yes 2 No Specify:	Specify: WHITE
8	hour	pe pe	****	adopte Head Convention	WIIIIE
7 .	n 72	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
7	withl ene. then	E E	Elementary/Secondary (0-12) College (1-4or 5+)	,	OLIN HOME
9	filed Hygid ther	Č	17. Father's Name (First, Middle, Last)	DMEMAKER 18. Mother's Name (First, Middle	OWN HOME
an	d be ental ced o	<u>m</u>	KOROEES HANA	ESMAH MAQSO	
Maryland 21215-0036	2 should be and Mental is marked or eumatic ev	J.		iling Address (Street and Number or Rural Route Numb	
Š	od 2 1th a 27 is r treu		ROGER MARKOS - SON 3288	GREENWICH CT., WALD	ORF, MD 20602
ā,	permit. Peges 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other treumatic once.		20a. Method of Disposition 20b. Place of Disp	position (Name of Date	20c. Location - City or Town, State
Baltimore,	eges ant of nt: If I		1 St Bunal 2 Cremation 3 Hemoval from State	ematory or other place)	E MALDODE MD
≣	artme ortar injur		91. 1111	R'S CH. CEM. 4-4-200 22. Name and Address of Facility	WALDORF, MD
ä	permi Depa Impo any Ir		mul. fox	RAYMOND FUNERAL SERV	ICE, P.A.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	LA PLATA, MARYLAND nter the mode of dying, such as cardiac or respiratory a	20646 Approximate
	anam.		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	tu live Conce	Interval between
	Prrysician /Medical		disease or condition resulting in death) a	in x/Vin Com co	in law J
	Examiner				
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events		
Ć,	sicien end burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):		
8760,	cate be ex physicien the buria	dicai	d		
9	death certificate e attending phys id for use as the	ledi			
Вох	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3		23d. Date of delivery
	deat	icia	1 Ves 2 PM2 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
P.0	the de by the a	Physician/Me	9 ☐ Unknown		
	es tha igned be del	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
ğ	w require been sig should b	ed	1 fylin Callinia	1 🗆	Yes 2 No 3 Probably 4 Whiknown
Records,	The law requires that the ite has been signed by th page 2 should be detache	ompieted	/*	24a. Wa	
æ	The lav ate has page 2	E		perf	prior to completion of cause of death? 2 No 1 Yes 2 No
Vital		De C	25. Was case referred to medical	26. Place of Death (Check only	
\$	Si Si	To B	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	ent 3 DOA Other: 4 Nursing Home 5 Res	sidence 6 Other (Specify)
J Of	Pa Tel		27. Manneyof Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 28d. Describe	how injury occurred
<u>.</u>	Attending r death. sctor: After by the fune	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	
Division		ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location City or To	(Street and Number or Rural Route Number, own, State)
	tel or rs afte el Dir	Cer			
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edicai	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. It date and place, and due to the cause(s)
	the the the the the the the the the the	Med	and manner stated.		
_	Twit To Jo	-	29b. Signature and title of certifler	29c. License number	29d. Date signed (Month, Day, Year)
			De price		APRIL, 4, 06
	1)		30. Name and address of person the completed cause of death (Item 23a) (Type	Print)	907
	V .		31. Date filed (Month, Daylear) 32. Redistrar's Signature.	odus Speryno 20	70-
	Sta Registr	-	31. Date filed (Month, Day/Fear) APR 1 4 2006 Server 1 4 2006	Carle	
	, legion		MINT A COOL MANAGED IN		

			For	State of M		d / Depa	artment o	of Heal	Ith and M	lental Hyg	_	C.	11921
			For State Registrar			Cei	tificate	of Dea	ath	,	g. No. U	0	11041
	Physici	an	Decedent's Name (First, Middle, Last		,	1				2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	E.		terr	4b. City, Tov		tion of Dooth	4_	4c. County	6	4:00 AM
	Examin	er	Charlestown Care								1	timor	~
	Funeral		5. Social Security Number 6. Se		je (In yrs.	last birthday)	_ If Under 1 Y		Inder 24 Hrs.	8. Date of Birth			elace (State or Foreign
	Director		074-20-6418	^{™ 2} 2 1 8	1	Yrs.	Months D	ays Ho	ours Min.	(Month, Day, 3-24-19	925	New	York
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	Od. Inside City Limits
	Aaryla f sho	ō			, 66. 6.								1 ☐ Yes 2 🛣No
	the 128a-	Director	Maryland Baltimor	e		Cato	onsvill 10f. Zip Co		•	1	Og. Citizen of N	What Cour	ntry?
	3e or		719 Maiden Choic	e Ln., Ap	t. H	R621	212	28			USA		
	deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U		Was Deceden	of Hispan	ic Origin? (Sp	ecify Yes or No- Rican, etc.)		e - Americ	
9	or ite	F	1 ☐ Never Married 2 🂢 Married	1 ☐ Yes 2 ☐X			1 □ Yes 2 🔀		ecity:	rticari, etc.;		ck, White, v: Whi	
Ö	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28a-f show ta Modical Exeminer must be inclifted at	d by	3 Widowed 4 Divorced	Year or Dates:									
15	in 72	Completed	15. Decedent's Ed (Specify only highest grad	ie completed)		(Give	dent's Usual O kind of work of DO NOT use r	lone during	most of work	ing	16b. Kind of B	usiness/in	dustry
212	y with piene. r thar	mo	Elementary/Secondary (0-12)	College (1-4or: 4 vears	5+)		acher				Educ	ation	n
פָּ	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)					18.	Mother's Nam	e (First, Middle, M	faiden Suman	ne)	
ylaı	Menta Menta arkad	10	Theodore G	ooch						Ethel La			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28a-f show any injury or other treumatic event, it a Medical Exercites must be nutified at once.		19a. Informant's Name/Relationship (7	ype, Print)						al Route Number			21228
e)	1 and Health em 27 ther t		Douglass B. Herri 20a. Method of Disposition	ng/ Husba			Maiden			Apt. H	20c. Location		/ille,MD
Baltimore,	ages or of the		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		cemetery, crei	matory or othe	r place)	1				
E	artmer prtent injury		*4 □ Donation 5 □ Other (Specify 21. Signature of Following Service Licenses		Ro		ek Ceme			eorge P.			
Ba	permi Depa Impo any i		> 1/11/1/1/							and Rd. H			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause	d the deal								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			-							Onset and Death
	/Medical		resulting in death)	a. Due to (or as	a consec	quence of):							
	Examiner		Sequentially list conditions,	b									
-	pe sit	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consec	quence of):							
	xecut and al-trar	хап	that initiated events resulting in death) Last	c Due to (or as	a consec	quence of):							
760,	icate be executed physician and s the burial-transit	calE	· ·	d									
9	ifficate g phy as the			<u> </u>									
Вох	leath certific attending p	an/N	230. Was decedent pregnant	23c. If yes, outcome 1□Live birth			∃Ectopic pregr	nancv				te of delive	*
	Physicien: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 Yes 2 No	4☐Pregnant a			Other (speci				Mo	onth	Day Year
P.0	that the dened by the a	Phy	9 ☐ Unknown Part II. Other significant conditions or		but not so	culting in the u	adachina agus	o organ in	Port I	23a Did tot	2000 1100 000	tributa to th	ne cause of death?
ds,	signe signe d be c	l by	End-stage			suiting in the d	riderlying caus	e giveri iit	raiti.		s 2 No		pably 4 Dinknown
of Vital Records,	w require been si should t	Completed		De ment						24a. Was a			
Rec	The law	ldm	Weight loss							autops perform	y ned?	prior to co death?	psy findings available mpletion of cause of
E	icien: Th certificate rector, pag	e Co	25. Was case referred to medical					26	Blace of Deal	1 ☐ Yes 2		1 🗌 Yes	2 □ No
>	nysicien: nis certifica director,	To B	examiner?	Hospital:	ient 2	ER/Outpatie	nt 3□ DOA	Othor		ome 5 Reside		ner (Specif	(v)
	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui	ury av Year)	28b. Time o	f 28c.	Injury at Work?		28d. Describe ho			
Siol	endir sath. or: Af he fu	catlo	2 ☐ Accident investigation		, ,		М	1 🗌 Yes	2 🗆 No				
Division	fter de direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	ijury - At h tc. <i>(Speci</i>	nome, farm, st	reet, factory, o	ffice		28f. Location (St City or Town		ber or Rura	al Route Number,
	pitel ours a eral C		29a. Certifier 1 Certifying Ph	ysician: To the best	of my len	nuladaa daat	h accounted at t	the time of	ate and alone	and due to the e			total d
	To the Hospitel or Attending PI within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Examone)	iner: On the basis of and manner s	of examina	ation and/or in	vestigation, in	my opinior	n, death occur	red at the time, d	ate and place,	and due to	o the cause(s)
	To the To To To To To To To To To To To To To	Me	29b. Signature and title of certifier				29c. L	icense nun	nber	2	9d. Date signe	d (Month,	Day, Year)
			Kleven Bur	vlin in	up		Dy	437	7.7		4/10	106	
	, h					m 23a) (Type,							
	12		30. Name and address of person who of Deneen Bowlin, M. 31. Date filed (Month, Day, Year) APR 1 4 2006	10 711 N	Maid	er Ch	tico L	und	, Cuto	nsville	, mo	212	28
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 / 2006	32. Regist	rar's Sign	ature	2						
	negist	rai	711 N I 4 2000	JAKE COM	Jed.	1							

			State of Maryland / Department of He State of Maryland / Department of He Certificate of D		, ,	iene 	11822
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	h	3. Time of Death
	Physici		Beverly Jo Hudgins		Month	21 2006	9:35 AM
	/Medio Examir			r Location of Death		4c. County of Death	
	ZXum		Franklin Source Haspital Rose	dale		Daltin	nove.
10	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birthi	place (State or Foreign
	Director		216-44-1667 1 M 2 F 57 Yrs. Months Days	Hours Min.	(Month, Day,	48 North	th Carolina
	p ,		Usual Residence of Decedent 10e. City, Town or Location 10a, State 10b, County 10c, City, Town or Location				
	aryla ehov	7					10d. Inside City Limits 1 ☐ Yes 2 ♣No
	r 28e-f ehow	ectc	DE Kent Dover				
	with t	ā	419 Derbywood Circle 1990	, il	10	Og. Citizen of What Cou	ntry?
1 .	deeth with the Maryland ime 23s or 28s-f show I must be indiffed at	Funeral Director		•	oity Voc or No	14. Race - Ameri	ann Indian
1	Item Instr	Š	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Yes 2 ☑ No	in, Mexican, Puerto F	Rican, etc.)	Black, White,	
336	urs af	by F	If Yes, Give 1 Yes 2 No Year or Dates:	Specify:		Specify: W	nite
70	within 72 hours after ane. then "naturel", or Ite		15. Decedent's Education 16a. Decedent's Usual Occupa			16b. Kind of Business/Ir	Idustry
215	hin 7	Completed	(Specify only highest grade completed) (Give kind of work done dife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	1)			1
2,5	d with	mo.	11 Foodservice	Manag	66	Service	America
200	al Hy I oth	Be C		18. Mother's Name			
<u>a</u>	should bind Ment	2	Joe C. Wells	myrtle	Enn	115	
S	C1 00 = 6		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a	\ \ \			
75	1 and Health em 27 ther tr		Timothy Hudgins 419 Derbywo			ver, de	19904
200	Jes 1 If ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	ce)		20c. Location - City or T	own, State
1 Hud	Pa ant:		4 Donation 5 Other (Specify) Capital Cremate		5/06	Dover,	De
- Ja	permit. Pages 1 and Depermit. Pages 1 and Important: If them 27 eny injury or other tr once.		21. Signature of Funeral Service Licensee 22. Name and Addres	ss of Facility	Phil	1 61 h. b	3 redderd XX
	40200		R. Carry powers	uneral	rugere	I Bown A	Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or simplications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	rcoma			Interval Between Onset and Death
8760,	be executed siclen and purial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):				
87	the the	dlcal	d				
Division of Vital Records, P.O. Box 6	ne death certifi the attending thed for use es	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □	,		23d. Date of deliv	rery Day Year
σ.	s thet the ned by a detect	Į.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
	quire on sig uld b	8 0			1 □ Ye	as 2⊡No 3⊡Pro	bably 4 Unknown
ဝွ	s bee	et			24a. Wasar	n 24b. Were aut	opsy findings available ompletion of cause of
æ	The la	E			autops perform	ned? death?	
ital	tifica	Bec	25. Was case referred to medical	26. Place of Death			240110
>	ysicl	10 E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	er: 4 Nursing Hor	me 5 ☐ Reside	ence 6 Other (Speci	fy)
0	ng Ph ter th neral		27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work	y at 2	28d. Describe ho	w injury occurred	,=
<u></u>	endir eth. or: Af	atic	2 Accident investigation M 1 1	Yes 2 □No			
Divis	s after de al Directo	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (St. City or Town	reet and Number or Rur n, State)	al Route Number,
	To the Hospital or Attending Physicien: The law requires the within 24 hours after deeth. To the Funeral Director: After this certificate hes been signed completely filled in by the funeral director, page 2 should be de	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time of the control of the desis of examination and/or investigation, in my operand manner stated.	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To ti withi. To ti	ž	29b. Signature and title of certifier 29c. License	e number	25	9d. Date signed (Month,	Day, Year)
			> >5hb) CSan Mb). 2256	541		3/21/20	06
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	John S	quare	Horpital	/
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature		1	T	

			1 - For State Registrar	State of M		nd / Depa	artmen	t of H		and M			0.0	6	118	23
	Physici	an	1. Decedent's Name (First, Middle, La	st)							2. Date of Dea Month	ith Day	,	/ear	3. Time of	Death
	/Media		CAMILLE G. HUSS								MARCH 25	, 200	6		2:30	A M
	Examir	er	4a. Facility Name (If not institution, given		er)		4b. City,	Town, or	Location of	ol Death		4c.	County of	Death		
			7400 CLIFFBOURNE COURS 5. Social Security Number 6.5		Age //n ure	last birthday)	DERV If Under		If Under	24 Hrs	9 Date of Birth		TGOME		alaaa (Ctata a	
	Funeral Director			1 ☐ M 2 Å F	89	Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day JUNE 14,	Year) 1916		Cour NEW	place (State o htry) YORK	r r-oreign
Н			Usual Residence of Decedent													
	urylan show	_	10a, State 10b, County	DV		ty, Town or Lo	cation							1	Od. Inside Ci	
	Ba-f	Director	MARYLAND MONTGOME	KI	1	DERWOOD									1 🗆 Yes	2 M NO
	72 hours after death with the Maryland 'naturel', or Items 23s or 28s-f ehow disel Examinar must be notified at	급	10e. Street and Number 7400 CLIFFBOURNE COU	RT			10f. Zip	Code 855				10g. Citiz USA	en ol Wh	at Cour	ntry?	
	eath mas 23	by Funeral	11. Marital Status	12. Was Deceder	nt Ever in II	S 13 V			spanic Ori	gin? (Sp	ecify Yes or No-			Americ	an Indian,	
10	r Iten	F	1 Never Married 2 Married	Armed Force	s?		I Yes, spec	cify Cuba	n, Mexican	, Puerto	Rican, etc.)		Black,	White,	etc.	
03	ref', o	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates	s:		¹ □ Yes	2 No	Specify:				Specify:	WHIT	Е	
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	kind of wo.	rk done d	turina mos	t of worki	ing	16b. Kir	d of Busi	ness/In-	dustry	
121	within ene. then	μpi	Elementary/Secondary (0-12)	College (1-40	or 5+)	HOMEM.	DO NOT us	se retired)			OUN	HOME			
5	be filed within 72 hours after death with the Marylan tie Hygliene id other than "naturel", or items 23a or 28s-f ehow event, its Medical Examinat must be notified at		17. Father's Name (First, Middle, Last)		Попы			18. Mothe	r's Name	(First, Middle,					
Maryland 21215-0036		To Be	ANTHONY TURECAMO	,						ILLE			,			
ary	shou ind M mar	-	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	g Address	(Street 2	and Numbe	r or Aura	al Route Numbe	r, City or	Town, St	ate, Zip	Code)	
	is 1 and 2 should of Health and Mer Item 27 Ie marke other traumatic		JERRI RUSH - DAUGHT	ER		1200 1	N. NAS	H STR	EET #8	20; A	RLINGTON	VA 22	209			
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 C	ARemoval from Sta	20b. F	Place of Dispo cemetery, crem ANTICO NA	sition (Nan	ne of ther plac	6) ETEDW		Date			•	own, State	
Ë	permit. Pages 1 Department of H Important: If Ite any Injury or ot		4 ☐ Donation 5 ☐ Other (Speci	(y)	QUA	_					/2006		NGLE,			
Bal	Depar Mpor Mpor Mny In		21. Signature of Funeral Service Lice Muzelin T	nsee	1						ES-RINALD ; SILVER				4	
	20244		23a. Part1. Enter the disease, or com												Approximate	Α
	P40-10140		shock, or heart failure. List only Immediate Cause (Final	one cause on each	i line.	EART FA			g, 020/ 20	00.000	n toophiatory an	001,			Intervat Bets Onset and I MONTH	ween
	Physician /Medical		disease or condition resulting in death)	a	as a conseq		LLUIG								2 PIONITIE	_
	Examiner			THIRD		E HEART	BLOCK									
	p =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a conseq	uence ol):										
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										_		
760,	ate be executed hysician and the burial-transit	cal E		Due to (or a	as a conseq	uence oi):										
687	phys s the			d								-				
Box (death certifica e attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								2	3d. Date	ol delive	ary	
	death	icia	in the past 12 months? 1 ☐ Yes 2 🎛 No	1☐Live birth 4☐Pregnant	at time of d		Ectopic pr Other (sp						Month	1	Day Y	/ear
0.0	at the by th	hys	9 ☐ Unknown	9□ Unknown								ļ				
	The law requires that the de ste hes been signed by the a page 2 should be detached f	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying c	ause give	n in Part I.			17			ne cause of d	
ord	w requir been si should	eted						**			1 L Y	es 2Ĉ	100 3	Prob	ably 4 🗆 U	Jnknown
Vital Records,	e law hes b	Completed									24a. Was a autops perfor	sv	prie	or to con ath?	psy lindings a mpletion of ca	available ause ol
alE			as we will also the								1 Yes	2 🖾 No			2□ No	
₹	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	tient 2 🗆	ER/Outpatien	t 3 DC	Othe			n <i>Check</i> only or πe 5[X] Resid		□ Othor	(Cnach		
o			27. Manner of Death	28a. Date of Ir	njury	28b. Time of		8c. Injury	at		28d. Describe h				<i>y</i> /	
ion	Attending r death. ector: After by the fune	atio	1 Naturat 5 Pending 2 Accident investigation	n	Day Year)	Injury	м	Work	res 2 □ l	No						
Division	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of	Injury - At he etc. (Specif	ome, farm, str	eet, lactory	, office		1	28I. Location (S City or Tow		Number	or Rura	l Route Numi	ber,
۵	Hoepital or 4 hours afte Funeral Dir tely filled in		Y													
	To the Hoepital or Attent within 24 hours after deati To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Exal	nysician: To the bearing: On the basis and manner	of examina	owledge, death ition and/or inv	occurred restigation.	at the tim , in my or	e, date an pinion, dea	d place, a th occurr	and due to the c ed at the time, o	ause(s) late and	and mann place, an	er as st d due to	tated. the cause(s))
	o the	Med	29b. Signature and title of certifier	and manner	3(d180.		290	. License	number		2	9d. Date	signed (Month,	Dey, Year)	
)	-		1427	1111) n	IN	1	D0057	896			2/	27/20	06		
	10		30. Name and address of person who	completed dause of	death (Iten	n 23a) (Type,		2002/	070			57	2,720			
			DAVID HIRSHFIELD, M.D.				HESDA,	MARY	LAND 2	0817						
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 20	37. Regis	strar's Signa	ature	elle)									
19	negisti	aı	MINU DIT CO	AND MARKET		1										

			For State Registrar	State	of Marylar				ealth a Death	and Mo	ental Hy	gien Reg. N	21111	6		324
		- 1	1. Decedent's Name (First, Middle	, Last)							2. Date of De		214	V	3. Time	of Death
и	Physici /Medic		DOROTHY ANNE HOWELL								Month MARCH 2			Year	10:4	5 A M
	Examin		4a. Facility Name (If not institution,	give street and n	um <i>ber)</i>		4b. City,	, Town, or	Location o	of Death		4	c. County of	of Death		
I.			BEDFORD COURTS		.,			ER SPR					ONTGOM			
	Funeral			6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	last birthday) Yrs.	Months Months	Days	If Under 2 Hours	Min.	8. Date of Bi	ay, Yeai		Coun	try)	or Foreign
	Director		579-09-2645 Usual Residence of Decedent		85	113.					JUNE 21,	192	0	NORTH	CAROL	INA
	yland 10W		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10	d. Inside	City Limits
	Man	ţo	MARYLAND MONTGOME	RY	SI	LVER SPR	ING								1 ☐ Ye	s 2KNo
	or 28,	Director	10e. Street and Number				10f. Zij	p Code				10g. C	itizen of W	hat Coun	try?	
	11 wil		3701 INTERNATIONAL	DRIVE				20906					U.S.A.			
	r dee	Funeral	11. Marital Status	12. Was De Armed f	cedent Ever in L Forces?	J.S. 13.	Was Dece f Yes, spe	dent of Hi	spanic Orig	gin? (Spec	cify Yes or No Rican, etc.)	0-	14. Race Black	- America		
20	or II	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, C	2 🕅 No Sive	1	1 ☐ Yes		Specify:					WHIT		
9500-6121	within 72 hours after deeth with the Maryland one. Than "naturel", or Items 23a or 28a-f show he Macical Examirer must be notified at	pa p	15. Decedent	Year or	Dates:	16a. Dece	lant'e Heu	al Occupa	ution			16h	Kind of Bus	unass/lad	ucto	
Ċ	i within 72 ho pene. r than "natur ne Modesi	Completed	(Specify only highes	grade completed	·	(Give	kind of wo	ork done d use retired	lurina mast	of workin	19	100.1	XIIIU OI BUS	111622/1110	ustry	
7	iene.	E	Elementary/Secondary (0-12) 12	College	(1-4or 5+)	HOMEMA	KER	S. Hillian				OW	N HOME			
Maryland 2	other	Bec	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle	, Maide	n Sumame)		
<u>a</u>	ould be Mental narked c	To E	HUBERT HARRIS						LUCY O	UTLAW						
a D	ss 1 end 2 should to of Health and Ment litem 27 is marked rother treumatic	•	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	g Addres	s (Street a	ind Numbe	r or Rural	Route Numb	er, City	or Town, S	tate, Zip	Code)	
	end ealth m 27		ROBERT HOWELL/SON						RI, PU		ORDA, FI					
ore	If Ite		20a. Method of Disposition 1 Burial 2 □ Cremation	3 ⊠Removal from		Place of Dispo cemetery, cren	sition (Na n <i>atory</i> or o	me of other place	e)	Da	ate	20c. l	ocation - (City or To	wn, State	
Ē	The man and		4 □Donation 5 □ Other (Sp	ecify)		CK CREEK	CEME	TERY	0	3/27/	2006	WASH	INGTON	, DC		
Baltimore,	permit. Pages 1 Department of H Important: If Ite ony Injury or ot		21. Signature of Funeral Service L	icensee		HI	NES-R	INALDI	s of Facility FUNER	AL HO	ME, INC.					
	TO S O O		23a. Part1. Enter the disease, or	Juae	wig	11	.800 NI	EW HAM	IPSHIRE	AVEN	UE, SILV	ER S	PRING,	MARY		-
			shock, or heart failure. List o	only one cause on	eachijine.	III. DO NOT GIN	er (ne mot	зө от аулц	, such as	cardiac or	respiratory a	irrest,			Approxima Interval Be Onset and	etween
	Pnysician /Medical	ΪÍ	disease or condition resulting in death)	_ a	C OBSTRUC		WAY D	ISEASE						-		
	Examiner			Due to	o (or as a consec	quence of);										
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consec	quence of):								+		
	d d ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с												
o o	exec en an rial-tr		resulting in death) Last		o (or as a consec	quence of):										
8/60,	death certificate be executed e ettending physicien and od for use as the burial-transit	dlcal		d												
ğ	ing ph	Med	IF FEMALE:	T	- 10 0.70 -						-					
X Q Q	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregn birth 2 ☐ Feta	al death 3	Ectopic p						23d. Date Mont		y Day	Year
	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pree 9□Unk	gnant at time of one of the communication of the co	death 5□	Other (sp	pecify)				ĺ	141011		Juy	· oai
ב ו	requires that the reen signed by th hould be detache		Part II. Other significant condition	ns contributing to	death but not res	sulting in the w	nderlying o	cause dive	n in Part I		23e. Did 1	tobacco	use contrit	oute to the	a cause of	death?
ď,	signed to	Completed by	ATHEROSCLEROTIC CARI			,	,					Yes 2				Unknown
ecord		ete									04-145-					
ě	The law ste has b	Ę	DEMENTIA (MIXED VAS	JULAR)							24a. Was auto perfo		pr de	or to con ath?	pletion of	s available cause of
		e Co	25. Was case referred to medical						00.51		1 ☐ Yes	2 🔼 N	0 1[☐ Yes	2 No	
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	EB/Outnation	, 3 🗆 D	Othe			<i>(Check only o</i> le 5 ☐ Resi	-	€ □Otho	(Specific	1	
	p Phys er this eral di		27. Manner of Death	2Ba. Dat	of Injury onth, Day Year)	28b. Time of		28c. Injury Work	at		8d. Describe				,	
<u></u>	Attending I ir death. ector: After by the funer	Certification;	1 Accident 5 Pending 2 Accident investig.		nm, Day rear)	Injury	M		? ′es 2 □ N	No						
DIVISION	il or Attence efter death Director: d in by the	112	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Plac	e of Injury - At h	ome, farm, str	eet, factor	y, office		2	8f. Location (City or To	Street a	nd Numbe	or Rural	Route Nu	m <i>ber</i> ,
5	ital or rs efte al Dir	Cer									0.0, 0. 10					
	Hospital	edical	(Check only 2 Medical E	Physician: To the examiner: On the	ne best of my kno basis of examina	owledge, death	occurred	at the tim	e, date and	d place, at	nd due to the	cause(s	s) and man	ner as sta	ited.	(e)
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medi	onej	and ma	nner stated.						1					\ -'r
	7 W. 1		29b. Signature and title of certifier	200	111		1	c. License					ate signed		uay, rear)	
	12.25		1 /3		4			050545	····-			MARC	H 24,	2006		
	13		30. Name and address of person v					T A 17 C M	A DADE	MADS	יים מווא די	01.2				
	Sta	to.	GODSWILL O. OKOGI, 31. Date filed (Month, Day, Year)		NEW HAMP:				A PAKK	, MAKY	LAND ZU	フエム				
ž.	Registr		MAR 2		Patiens o	B. A.	reste	9								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL **Physician** ARTHUR FRANKLIN JONES, SR. 2006 5:30p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Chestertown Nursing & Rehab Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug 25 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1920 Maryland 1**X** M 2□ F 85 Yrs Director 220-28-0558 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. Count 10c. City. Town or Location 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 1 No MD Chestertown Director Kent 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21620 U.S.A. 5886 Honest Point Lane death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: if itam 27 is markad other than "natural", or fte 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Kent County Board Elementary/Secondary (0-12) College (1-4or 5+) of Education Carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Doller Jones Ida Mable Elburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if itam 27 is any injury or other traignes. 23456 Lovely Lane Chestertown, MD. 21620 (daughter) Mable J. Myers 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Chester Cemetery 4/11/06 Chestertown, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Galena Funeral Home of Stephen L Schaech 21. Significant of Fun al Service Law see 118 West Cross St. Galena, MD. M00510 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in ceath) diovascular gear Physician Herio sche /Medical Lue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Pe 1 Yes 2 No 3 Probably 4 Unknown tension page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Diractor: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28c. Injury at Work? 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 17036 - md 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Are. Chestatoron Md 21620 Ko3 516 39. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 4 2006 Registrar

			For State Registrar	State of M	Marylan		artment rtificate			and Me	ntal Hy	gien	006	11826
4-76		8	1. Decedent's Name (First, Middle	, Last)						2	2. Date of De Month		ay Year	3. Time of Death
	Physici /Medic	_	Ruby Rebecc	a Johnso	n					1	April		2006	11:00A ^M
	Examin	_	4a. Facility Name (If not institution,						Location o	of Death			c. County of Death	
		¥.	Washington A				T a	akon	1a If Under 2	24 Hrs. I n	. S 4 B:		lontgome	
46	Funeral Director		5. Social Security Number 245-38-8124	6. Sex 7. / 1 M 2 TF		last birthday) '79 Yrs.		Days	Hours	Min.	Date of Bir (Month, Da	ay, Ye <i>ar</i>	1927	nplace (State or Foreign untry) NC
7			Usual Residence of Decedent	-		19	i				1al Cli		1 1 3 2 1	IVC
	how		10a. State 10b. County			y, Town or Lo								10d. Inside City Limits
•	the Marylan 28a-f ahow notified at	cto	MD. PG		Мо	unt R	ainie	er						1 ☑ Yes 2 ☐ No
	or 24	Dire	10e. Street and Number	- "			10f. Zip						itizen of What Co	•
	s 23s	rai	4201 Russell			C 12		0712		ain? (Space			ted Sta	
	Itam Itam	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deceder Armed Force ed 1 ☐ Yes 25		.3.	If Yes, speci	ify Cubar	, Mexican	n, Puerto Ri	fy Yes or No can, etc.)	,	Black, White	, etc.
215-0036	72 hours after death with the Maryland natural', or ltarns 23a or 28a-f ahow disal Examinat must be notified at	Ď	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	-		1 ☐ Yes Z	X No	Specify:				Specify: Bla	ck
2	72 ho	Completed	15. Decedent' (Specify only highest	's Education		16a. Dece	dent's Usual kind of work DO NOT use	l Occupa	tion	t of working	,	16b. i	Kind of Business/I	ndustry
21	within ene. than "	npie	Elementary/Secondary (0-12)	College (1-4c	or 5+)							777	Hoard	L - 1
121	lled w lygier ther th		1 2 17. Father's Name (First, Middle, L	acti		рте	tary			r's Name /	First, Middle		A Hospi	tal
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Itam 27 Is marked other than "natural", or Itams 23e or 28s-f show other traumatic avant, the Medical Examinationals be notified at	o Be	Zenias A. Hu								L. Ca			
J.	shoul nd Me mari	٦	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address	(Street a	n <i>d Numb</i> e	er or Rural I	Route Numb	er, City	or Town, State, Z	ip Code)
	1 and 2 Health a tam 27 la		Minnie Burrou	ghs/daugh	nter	4201 Moun	Rus	sel:	l Av	enue	#3 20712	,		
J.e.	of He of He item		20a. Method of Disposition	2 CP		MOUD Place of Dispo cemetery, crei	sition (Nam matory or oti	e of her place)	Dat	19	20c. l	ocation - City or	Town, State
Ē	Pages ment of B ant: If its ury or of		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		Ft.	Line				/11/			entwood	
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other ance.		21. Signature of Funeral Service L	icensee	1)					_		dwards	
	907 g ol		janice	Edwar	de								itland,	MD.20746
			23a. Park. Enter the disease, or shock, or heart failure. List of	complications that caus only one cause on each	sed the deat n line.	n. Do not ent	er the mode	e or aying	, such as	cardiac or i	respiratory a	irrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Chron			ctive	Lu	ng D	isea	se			
	Examiner			Due to (or :	as a conseq	uence or):								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a conseq	uanca of):								
V	cuted nd ransit	amir	trial initiated events	c.										
0	cate be executed obysician and the burial-transit	Ex	resulting in death) Last	Due to (or	as a conseq	uence of):								
8760,	certificate be executed ding physician and ise as the burial-transit	Physician/Medical Examiner		d										
9 ×	leath certifica attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregna	ancv							23d Date of deli	
Вох	ath tter or u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Feta	Ideath 3	Ectopic pre						23d. Date of deli Month	Day Year
0	that the d ed by the detached	hysi	1 □ Yes 2 XNo 9 □ Unknown	9□ Unknown										
٥.	ires that the dei signed by the a f be detached f	by P	Part II. Other significant condition	ns contributing to death	h but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
ğ	w requires been sign should be	edt									1 🖎	Yes 2	2□No 3□Pro	bably 4 □Unknown
Records,	× 4 5	Completed									24a. Was		24b. Were au	topsy findings available ompletion of cause of
H	Physician: The lav this certificate has al director, page 2	Con									perfe 1 Yes	ormed?	death?	2 ☆ No
Vital	ician: entific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	Check only	one)	7-11	
of	Physician: this certific ral director,	To.	1 ☐ Yes 2 📉 No 27. Manner of Death	28a. Date of It		ER/Outpatier 28b. Time o			4 🗆 140				6 Other (Spec	uty)
UO	fe fe	tlon	1 ZNatural 5 ☐ Pending 2 ☐ Accident investig	g (Month, i	Day Year)	Injury	M	Bc. Injury Work 1 ☐ Y	?ີ່ ′es 2 🔲 I		d. Describe	now any	ary occurred	
Division	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could n	not be 28e. Place of			reet, factory,	, office		28				ral Route Number,
Ö	s afte	Certification;	4 🗆 Homicida	building,	etc. (Specif	'Y)					City or To	wn, Sta	re)	
	To the Hospital or Attendi within 24 hours after death. To tha Funeral Director; A completely filled in by the fu	Medical (29a. Certifier 1 X Certifying (Check only one) 1 Medical 8	g Physician: To the be Examiner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date an inion, dea	d place, an th occurred	d due to the l at the time,	cause(date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and tale of certifier			Pni		License	number	1		29d. D	ate signed (Monti	, Day, Year)
				2	وزر	(11)		1)	1)6	60		4/6	6/06	
	1		30. Name and address of person											
1	H		Dr. Dpinder S	Singh, M.D	. , 14	1300 C	alen	t F	ox L	ane,	_Bow:	ie,	MD. 20	715
	Sta Regist		APR 1 4	2006 32 legi	Contra Signa	y for	and I							
1	, in (63)	No.		1-00		-/								

			For State Registrar	State of	f Mary	land / Dep	oartmen e <i>rtificat</i>				lental Hy	giene	UUb	11827
	.		1. Decedent's Name (First, Middle	, Last)							2. Date of De	eath Da	y Year	3. Time of Death
	Physicia /Medica		Richard A. Jo	hnson							March	27,	2006	12:40 a M
	Examine		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	r Location	of Death		4c	. County of Deat	h
			Suburban Hospit					ethe					Montgon	
	Funeral			6. Sex 1.24M 2□ F		yrs. last birthda SQ Yrs.	y) If Under Months		If Under Hours	Min.	8. Date of Bi (Month, Da	rth ay, Year)	9. Birtl	hplace (State or Foreign untry)
	Director	}	505-46-0710 Usual Residence of Decedent			68 Yrs.					April :	18,	1937 Was	shington, DC
land	A =		10a. State 10b. County		100	c. City, Town or	Location							10d. Inside City Limits
Mary	= 3	ģ	Maryland Mont	gomery		Silver	Sprin	~						1 ∐ Yes 2 % ⊡ No
the	1.28e	rec	10e. Street and Number	90.1017		SIIVCI	10f. Zip					10g. Cit	tizen of What Co	untry?
h with	23a o	0	1214 Noyes Dr	ive			2	0910				U	SA	
deat	, or items 23a or 28e-f ehow taminer must be notified at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever	in U.S. 13	. Was Dece	dent of Hi	ispanic Or	rigin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	rican Indian,
after a	P B	2	. 1 ☐ Never Married 2 📉 Marrie		2 X No		1 ☐ Yes				riidan, etc.)		Specify Whit	
0036	= 02	d b	3 Widowed 4 Divorced	Year or E	ates:									
Z OF	nat	Completed	15. Decedent' (Specify only highes			16a. Dec	edent's Usua ve kind of wo . DO NOT u	nk done d	ation during mos	st of work	ing	16b. K	ind of Business/	Industry
125 de	then N	mg	Elementary/Secondary (0-12)	College (1·4or 5+) ⊢		nglish					E	ducation	1
MACA A COCK COCK A 21215-0036			17. Father's Name (First, Middle, L	.ast)				- 1			e (First, Middle	1		
Maryland 2 should be		To Be	Cecil A. Johns	on					Es	ther	M. Nel	lson		
- 000 %	of Health and Ment		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Ma	iling Address	(Street a	and Numb	er or Rur	al Route Numb	er, City o	or Town, State, 2	Tip Code)
E 0 ≥ 5:	Health Iem 27 i		Michaela Johnso	n/ Wife							E 4	_	, MD 209	
Shnsc 327 limore,	or it		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from		Ob. Place of Dis				March	28,	20c. Lo	ocation - City or	Town, State
중요 교	tant:		4 Donation 5 Other (Sp		l L	Metropoli		_		200	-			Virginia
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			23a. Part. Enter the disease, or shock, or heart failure. List of	complications that only one cause on o	aused the each line.	death. Do not e	nter the mod	e of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition	Multi	ple M	Myeloma								Onset and Death 6 Years
	ledical aminer		resulting in death)	Due to	(or as a cor	nsequence of):								
_^	A	_	Sequentially list conditions,	b	for an a and	ntierunnoa ofic								
pe	ısit	nine	Sequentially list conditions, they leading to immediate cause. Enter Underlying Cause (Disease or injury	(Jule 10	(or as a row	mercummaa orgi.								
, xecu	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a cor	nsequence of):								
8760,	D I G	Cai												
68 ifficat		edic												
Box 6	attending ph for use as th	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou				5					23d. Date of deli	very
a geag	e atte	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time		□Ectopic pr □ Other (sp						Month	Day Year
P.O.	ed by the	, hys	9 Unknown	9LJ Unkn	own									
S, 1	gue d	à	Part II. Other significant condition	ns contributing to d	eath but no	t resulting in the	underlying o	ause give	en in Part I	l.				the cause of death?
Division of Vital Records,	been s	Completed									10	Yes 2	⊡NO 3∐FR	obabfy 4 Unknown
e law	has b	odu.									24a. Was	psy	24b. Were au	topsy findings available completion of cause of
E 4	cate he										1 Yes	ormed? 28 No	death? 1 ☐ Yes	2 No
Vita		Be	25. Was case referred to medical examiner?	Hospital:				Othe			h (Check only			
Phys.	rahis naldi	ို	1 ☐ Yes 2X No 27. Manner of Death	114		2 ER/Outpati		8c. Injury	4 □ Nu		me 5 Resi 28d. Describe		6 Other (Spec	cify)
Ongula	After funer	盲	1 XX atural 5 ☐ Pending investig		of Injury th, Day Yea	ar) Injury	м	8c. Injury Work	k? Yes 2 □	i			,	
/iSi	er death. rector: Al by the fu	lica	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place	of Injury -	At home, farm, s	street, factory	, office			28f. Location (Street an	id Number or Ru	ral Route Number,
Div	od in the	Certification:	4 Homicide determine	build	ing, etc. (St	oecify)					City or To	wn, State	9)	
Division of Vital Records, P.O. Box 68760, Prospitel or Attending Physician: The law requires that the death certificate be executed		Medical	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the xaminer: On the b and man	best of my asis of examer ner stated.	knowledge, de mination and/or	ath occurred investigation	at the tim , in my or	ne, date ar pinion, dea	nd place, ath occurr	and due to the red at the time,	cause(s) date and	and manner as d place, and due	stated. to the cause(s)
To the	To the	Ž	29b. Signature and Itle of centier				290	. License	e number			29d. Da	te signed (Month	n, Day, Year)
			1					D62	2234			Marc	h 27, 2	006
1	0		30. Name and address of person w Manish Agrawal			(Item 23a) (Type Medical		er Dr	cive,	Roc	kville,	MD	20850	
	L.								•					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** March 27,2006 Johnson Alphonsus 4:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Clinton Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or F Month, Days Hours Min. Sept. 25, 1936 Maryland 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□ F 215-36-5081 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County itam 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic event, it a Marical Examinar must be notified at 1 X Yes 2 ☐ No Prince Georges Upper Marlboro Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9712 Muirfield Dr. 20772 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 • by ▶ 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) County Government 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnson Josephine Galloway Maurice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any Injury or other traum once. 9712 Muirfield Dr. Upper Marlboro, Md. Mary Yvonne Johnson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🎇 Burial 2 ☐ Cremation 3 ☐ Removal from State ^ 4 ☐ Donation 5 ☐ Other (Specify) Washington National 4/1/06 Suitland, Md. 21. Signature of Fineral Gervice Lic 22. Name and Address of Facility ADAMS FUNERAL HOME, PA 20605 Aquasco Rd., Aquasco Md. 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician HRomsvaytor /Medical Due to (or as a consequence 4): Examiner ANDMIA Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day Year 4 Pregnant at time of death 5 Other (specify) à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 24a. Was an 71190 / 2 **12** No 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies D35206 march 28, Zwb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11701 Livingsom Road Fort WASHington WILLIAM T. TANNER MY 32. Pogistrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 1 2006 Registrar

			FOI	partment of Health and M	lental Hygie	ene	1.1000
			1.103,101.01	ertificate of Death		and Ub	1829
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Ethel Virginia Kasulke 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March 27	4c. County of Deat	1:40 p M
	Examin	ei	359 Jewell Road	Dunkirk		Anne Arur	
5 1 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4 1 4	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y		nplace (State or Foreign untry)
	Director		214-42-5159 ^{1□M 2} √√F 94 Yrs	Monato Bayo Hadaa			ginia
3	* H		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	mary led	tor	MD Anne Arundel Dui	kirk			1 ☐ Yes 2 🔀 No
4	daath with the Marylend ms 23s or 28s-f show Titust to Dictified at	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?
1	238	ral	359 Jewell Road	20754		U.S.A.	
	items interna	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
ر ا	z nours atter daam with the maryler atter? or frems 23s or 28s-f show cal Examinat hat the trivillist at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Wh	ite
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V 1	Hygier Hygier thar ti		12 ho	memaker	e (First, Middle, Ma	own hom	ie
and	kad of	To Be	Luther M. Myers	Maude	Hunter	Brown	
<u>-</u>	2 4 4	Ě		iling Address (Street and Number or Rur			Tip Code)
Ma Ma	125		Ethel M. Thomas, daughter 363	Jewell Road, Dunk	irk, MD	20754	
ore	ges ren it of Heall if item 2 or other		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, of the complete of the	rematory or other place)		c. Location - City or	Town, State
Баітіто	nit. Peges lertment of ortant: if it injury or o		4 □Donation 5 □Other (Specify) Epiphan		1-2006 Fo	prestville	e, MD
Da	Depertment of important: if it any injury or one		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Rausch Funeral Hom	e, P.A.,	Owings, M	D 20736
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
P	hysician		V 1	dral Infarction	1		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a considence of):	8 8 10			
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မ	as be	Completed	Hypertentin		24a. Was an autopsy	prior to d	topsy findings available completion of cause of
	scertificate has t irector, page 2 s	Con	Anemia - multifactorial		performe		2□ No
Vital	is certific director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:		h (Check only one)		
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	To the hospital of Attentivities within 24 hours effer deell To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de (Check only one) 2 Medical Examiner: On the basis of examination and/on and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	within 2 To the comple	ž	29b. Signature and title of certifier	29c. License number		. Date signed (Monti	
			Derald P, Sterner m.D.	D 17245	1	runch 28	,2006
	6		30. Name and address of person who completed cause of death (Item 23a) (Typer Gerald P. Sterner, M.D. 19 Chesa		Owinas.	MD 20736)
K	Sta		31. Date filed (Month, Day, Year) 32. Registrates Signature				
	Registr	ar	MAR 3 0 2005 € Server &	Aparte			

		For State	State of Marylar		rtment of H tificate of I			6.000	11830
		Registrar 1. Decedent's Name (First, Middle, Last,		001	uncate or i	Jealii	2. Date of Deatl	og. No.	3. Time of Death
Physici		CECELIA		LLEY			Month	Day Year	M
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	March 2	9 2006 4c. County of Dea	10:30 P [™]
Exami		20121 WARINGWOOD	WAY		MONTGOM	ERY VILL	AGE	MONTGO	MERY
Funeral		Social Security Number 6. Security Number		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign
Director		196 01 1116	M 2.27 91	Yrs.		Tiodio Mini.	Nov. 20	,1914 PEN	MSYLVANIA
and *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Loc	cation				10d. Inside City Limits
Manyl, f sho	ō	MD. MONTGOME	DΥ	MONTGON	MERY VILL	AGE			1 □ Yes 2 No
28a-	rec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What C	country?
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death	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Race - Am Black, Wh	
after after	y Fu	1 Never Married 2 Married	1 Yes 2 No If Yes, Give Year or Dates:		☐ Yes 25 No	Specify:	1110411, 0(0.)	Specify:	WHITE
ified within 72 hours after death with the Maryland Hygiene Hygiene Hygiene Than "natural", or Items 23e or 28e-f show ant, the Macrical Examiner must be motified a left.	d b	3 Widowed 4 □ Divorced							
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iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		EMAKER			OWN HOME	
a filec I Hyg otha	Se C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, N	faiden Sumame)	
uld be Menta Irked	ToE	CHARLES JORSKY				JOSEPH:	INE	(UNKNOWN)	
2 sho and 1 and 1 s ma		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street a	and Number or Run	al Route Number,	City or Town, State,	Zip Code)
and and m 27 m 27 nar tr			ON						MD. 20886
Parity Hotel		20a. Method of Disposition 1 ☐ Burial 2 ★Cremation 3 ☐ F	lemoval from State	cemetery, crem	sition (Name of natory or other place	9)		20c. Location - City o	
t. Partmen		'4 □Donation 5 □ Other (Specify)				tory 3/30		ALE XANDR I A	1, VA.
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Deparmit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural, or Items 23a or 28a-1 show any injury or other traumatic event. The Modes Examiner must be notified at once.		21. Signature of Funeral Service Licens Muciel	* Bay			BARBER FU 038 LAY			182
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the deat			-			Approximate Interval Between
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r Attane ter death iractor: by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At he building, etc. (Specif		et, factory, office		28f. Location (Str City or Town,	eet and Number or F , State)	lural Route Number,
urs afte									
To the Hospital or Attanding Physician: The law requires that the death certif within 24 hours after death. To the Funcatal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.						
o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed Mon	th, Day, Year)
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V		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type, !	Print)			117	1
		JAMES MÁTTHEWS, M	I.D. 981 RUSS	SELL AV	ENUE, GAI	THERSBUR	G, MD. 2	0879	
Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature do	refer				
Registr	ar	MINU OT TO	12000						

			1 - For State Ragistrar	State of M	laryland	•	irtment of				giene Reg. No.	5	11831
			Decedent's Name (First, Middle, La.	st)						2. Date of Dea	ath		3. Time of Death
	Physici		Mark	Guy	LeFe	aura				Month MARCH	28, 200	Year 06	4:31P. M
	/Medio Examin	•	4a. Facility Name (# not institution, give			7410	4b. City, Town	n, or Location	of Death	1111011	4c. County		
	LAGITIII		FORD ROAD @ W, SH	ADY STDE I	ROAD		SHADY S	SIDE			ANNE A	RUND	EL
	Funeral		5. Social Security Number 6. S			ast birthday)	If Under 1 Ye		er 24 Hrs.	8. Date of Birt	h Vans	9. Birth	place (State or Foreign
	Director		578-86-3213	MM 2□F	48	Yrs.	Months Day	ys Hours		(Month, Day Mar. 1		Ala	
	P .		Usual Residence of Decedent		10.00								
	arylar	L	10a. State 10b. County		10c. City	r, Town or Lo	cation						10d. Inside City Limits
	Ba-f.	ct c	MD Anne Ar	undel			Shady	Side					1 ☐ Yes 2 No
	or 2	Die.	10e. Street and Number				10f. Zip Cod				10g. Citizen of W	hat Cou	ntry?
	s 23s	Funeral Director	6400 West Shady	Y				764			USA		
	er de item	T P	11. Marital Status	12. Was Decedent	?		Vas Decedent of Yes, specify C	of Hispanic O Suban, Mexica	rigin? (Spe an, Puerto F	city Yes or No- Rican, etc.)		r - Amen k, White,	can Indian, , etc.
36	rs aft	by F	1 Married 2 Married 3 Widowed 4 Divorced	1 12 Yes 2 ☐ If Yes, Give Year or Dates:	1982_	84	☐Yes 2🎇 N	No Specify	y:		Specify:	wh	ite
21215-0036	within 72 hours after deeth with the Maryland ene. then "netural", or items 23a or 28a-f show the Madical Examiner must be notified at	ed	15. Decedent's Ed		1502		lent's Usual Oc	cupation			16b. Kind of Bu		
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ğ	Hygothe other	Be C	17. Father's Name (First, Middle, Last)	1	····			18. Moth	her's Name	(First, Middle,	Maiden Sumam	ө)	
<u>a</u>	Aenta Aenta rkad tic ev	To B	Gerald Henry	LeFe	vre			Jen	nie	Rutl	n Ha	rris	son
Maryland	permit. Peges 1 and 2 should be lifed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Important: if item 27 is marked other then. Instural; or itema 23a or 28a-f show supringury or other traumetic event, the Madical Examiner must be notified at ance.		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Stre	eet and Numi	ber or Rura	Route Numbe	er, City or Town,	State, Zi	o Code)
Ž	and 2 selth n 27 i		Mitchel A. LeFev	re, broth	er	452 1	Wilson	Court,	, Frie	ndship	, MD 20	758	
e e	of He	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domoval from State		lace of Dispos emetery, crem	sition (Name of natory or other p	place)	- D	ate	20c. Location -	City or T	own, State
Ĕ	Peg ment ant: i		4 Donation 5 Other (Specif		So.	Memor	rial Gar	rdens	04-05	-2006	Dunkirk	, MD	
Baltimore,	partr ports y inje		21. Signature of Funeral Service Licer	nsee		22	. Name and Ad	dress of Faci	ility				
Ω_	89 = 8		Williams	· Crow	_	R	ausch F	uneral	L Home	, P.A.	, Owings	, MI	20736
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death line.	. Do not ente	er the mode of o	dying, such a	is cardiac oi	respiratory ar	rest,		Approximate Interval Between
	Physician	0.3	Immediate Cause (Final disease or condition	ASPHY	XI A							-	Onset and Death
7	/Medical		resulting in death)	Due to (or as		ience of):							
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×	entific ding p	Me	IF FEMALE:	225 16 1155 511555								1	
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Division of Vital Records,	slgne d be			•		•	, ,	•		1 🗆 Y	es 2 No	3∐ Pro	bably 4 □Unknown
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ဆို	hes law	Completed								24a. Was autop	sv p	rior to co	opsy findings available empletion of cause of
<u></u>	ysicien: The lavis certificete hes director, page 2										2 □ No 1	Yes	2 □ No
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LO O	ding h. After fune	E I	1 ☐Natural 5 ☐ Pending	FOUND Month, D	ay Year)	Injury	V	Work? I∐Yes 2.2		SUBTEC		D F	PANGING
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	To the Hospital or Attanding Physicien: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending p complately filled in by the funeral director, page 2 should be detached for use as:	edicai		ninar: On the basis and manner s	of examinat	ion and/or inv	estigation, in m	ny opinion, de	eath occurre	d at the time,	date and place, a	nd due t	o the cause(s)
	To th withir Fo th	Me	29b. Signature and title of certifier				29c. Lice	ense number	r		29d. Date signed	(Month,	Day, Year)
			> anesz				C	C.M.E	Ε.]	MARCH 29	, 20	006
	Δ .		30. Name and address of person who	completed cause of	death (Item	23a) (Type. I	Print)						
	2+1		ANA RUBIO, 1			, , , , , , , , ,	111 PEN	IN STRE	EET BA	LTIMOR	E MARYLA	ND 2	21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	raes Signat	ture	<i>i</i>	6	·				
	Registr	ar	MAD 2	1 2005	Barrer .	. 18	Books	1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** FUNG CHUN LIM-WONG 23 2006 MARCH 1:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPRING WOODSIDE CENTER MONTGOMERY If Under 1 Year 8. Date of Birth (Month, Day, Ye 3/25/1911 Birthplace (State or Foreign Country)
 CHINA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Days Hours 1□ M 20 F Yrs 568-74-5908 94 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural; or items 23a or 28e-f ahow any injury or other traumatic event, the Medical Evanting must be mailfied at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND. MONTGOMERY SILVER SPRING 1 ☐ Yes 2 🕅 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10926 NEW HAMPSHIRE AVENUE 20903 Funeral CHINA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à Specify: WHITE 3 ☐Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK 6 RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN UNKNOWN ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY WONG - DAUGHTER 10926 NEW HAMPSHIRE AVENUE; SILVER SPRING MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State GEORGE WASHINGTON CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 3/25/2006 ADELPHI, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 11800 NEW HAMPSHIRE AVE.; SILVER SPRING MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 vursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research BLVD Suite 330 Rockirch mp 2:850 Mendhiratti 2401 31. Date filed (Month, Day, Year) State

Registrar

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2006

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			_ For	State of Ma		Departme	ent of H	lealth and l	-	-0.07) 6	833
			1 - State Registrar			Certifica	ate of	Death		Reg. No.		
н	Physici	an	Decedent's Name (First, Middle, La	st)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Frank A. Lyle						March	29,	2006	4:40 p⁴
7	Examir	er	4a. Facility Name (If not institution, giv			4b. Ci	ty, Town, o	r Location of Death	1	4c. Coun	ty of Death	
			Shady Grove Adve				ockvi. der 1 Year	11e If Under 24 Hrs.	1		gomer	*
	Funeral		5. Social Security Number 6. S 426-78-1387	ex 7. Ag ⊠M 2□F	e (In yrs. last bii 7 1	Yrs. Month		Hours Min.	(Month, Da	th ly, Year)	Cour	
	Director		Usual Residence of Decedent		71				April 1	5,1934	MISS	sissippi
	ehow		10a. State 10b. County		10c. City, Tow	n or Location					1	0d. fnside City Limits
	the Mar 28a-f el	tor	Maryland Montgon	nery	Gaithe	ersburg						1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of	What Cour	ntry?
	15 w	a	9308 Bathgate Cou	rt			20886			United	l Stat	es
	itema itema	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. Was De If Yes, s	cedent of H pecify Cuba	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No o Rican, etc.)		ce - Americ	
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ I If Yes, Give		1 ☐ Yes	2⊠ No	Specify:		Spec	fy:	
8	"natural",	D D	15. Decedent's Ed	Year or Dates:		. Decedent's U	sual Ossus	ation		16h Kind of	Whi	
5	in 72	Completed	(Specify only highest gra	ide completed)		(Give kind of life. DO NO)	work done	durina most of wor	king	16b. Kind of I	ousiness/in	dustry
12	within iene. than "	E	Elementary/Secondary (0-12)	College (1-4or 5		Busines		,		Stockh	roker	age
D	a filed within Il Hygiene. other than	BeC	17. Father's Name (First, Middle, Last,				Jindii	18. Mother's Nan	ne (First, Middle,			uge
a	Med be ked	To B	Burton E. Lyle					Kathrvi	n Beatri	ce Chil	icoat	
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	alth a		James Lyle / Son		93	08 Batl	ngate	Court; (Gaithers	burg, M	ary1a	nd 20886
ē,	of Herm item		20a. Method of Disposition			f Disposition (A			Date	20c. Location		
Ĕ	Page nent c int: if		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification)		i			tory 4/3/	/2006	Brentw	ood,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funer I Service Liver	isee / /a A		Same	and Addre	ss of Facility Dute Fune	ral and			
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Division of Vital Records,	Attending Physician: r death. ector: After this certifics by the funeral director, p	7; To	27. Manner of Death	28a. Date of Inju	ry 28b.	Itpatient 3 Time of	28c. Injun Worl	4 Nursing n	ome 5 Resident			y)
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 ☑ Certifying Ph	ysician: To the best	of my knowledge	e, death occurre	ed at the tin	ne, date and place	, and due to the	cause(s) and n	nanner as st	tated.
	he Hi in 24 he Fi piete	Medical	one)	niner: On the basis of and manner sta	ted.	or investigati	on, in my of	pinion, death occu	rred at the time,	date and place	and due to	the cause(s)
	To T	Σ	29b. Signature and title of certifier	1.1		2	29c. License	e number		29d. Date sign	ed (Month,	Day, Year)
			west A	rully	N	10	D265	640	1	March 2	9, 200	06
	21		30. Name and address of person who		eath (Item 23a)	(Type, Print)						
-	20		Carl I. Schoenber			0 Frede	rick	Road #21	3; Gaitl	nersbur	g, MD	20877
	Sta		31. Date filed (Month, Day, Year) MAR 3 1	32. Pogistra	ar's Signature	A N						
	Registr	aı	mall of t	LUUU BRIE	W 10.	LICE VEL						

4 2		- 100	1 - State Registrar Amend Ttem #13&14 Per 1. Decedent's Name (First, Middle, Last)	FH G855	5/f1706	Jeath		ate of Deat		000	3. Time of Deatl	n T
	Physici /Medic		RODRIGO JOHN MOURĖ					Month PRIL	5 ,	2006	1:10 A	М
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	within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-f show the Madical Examillar must be notified at	Funeral Director	10200 LA PLATA ROAD		206	46		,	-	S.A.	, and a second	
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and	be file ital Hy doth	Be	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (Fir	st, Middle, I	Maiden S	Surname)		
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<u>8</u>	id 2 sl Ith and 27 Is r traur		19a. Informant's Name/Relationship (Type, Print) ANITA MATTINGLY-DAUGHTER		g Address (Stree							
စ်	of Health item 27 other to		20a. Method of Disposition	b. Place of Dispos			Date			ation - City or		
timore,	Pages ment of ant: If i		1XXvurial 2 □ Cremation 3 □ Removal from State 4 4 □ Donation 5 □ Other (Specify) ST.	IGNATI			4-10-	-06	CHA	PEL P	OINT, MD	
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מ	20 E P 9		23a. Part 1. Enter the disease, or complications that caused the disease.		RAYMONI La Pla							
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XOX C	death certificate le attending phys ad for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant		-				23	3d. Date of del	livery	
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ř	0 4 0	dmo						24a. Was ai autops perforn	y	prior to death?	utopsy findings availa completion of cause (ble of
Vital	ician: Th certificate rector, pag	O	25. Was case referred to medical			26 Place o	of Death (Ch		No No	1 🗆 Yes	2 🗆 No	_
	<u>\$</u> .∞ 5	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 DOA O					□Other (Spe	cify)	
n or	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day Yea	z8b. Time of Injury	28c. Inj			Describe ho				
<u> </u>	or Attending ifter death. Director: After in by the fune	catl	2 Accident investigation		M 1[]Yes 2 □ No						
DIVISION	of or Attendate after death	Certification:	4 Homicide determined 28e. Place of Injury - / building, etc. (Sp.	At nome, farm, stre necify)	et, factory, office	9	281. (ocation (St.	reet and 1, State)	Number or Au	ural Route Number,	
	To the Hospital or within 24 hours aft to the Funeral Discompletely filled in		29a. Certifier Certifying Physician: To the best of my	knowledge, death	occurred at the	time, date and	place, and o	lue to the ca	ause(s) a	ind manner as	s stated.	
	he Ho in 24 t he Fu pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or inv	estigation, in my	opinion, death	occurred at	the time, da	ate and p	place, and due	to the cause(s)	
	To t To t	Σ	29b. Signature and title of pertifier		29c. Licer	nse number	G C.	25	9d. Date	signed (Mont	h, Dey, Year)	
}	1x		I hard		Do	10579	1-1		4	15106		
	2,		30. Name and iddress of person who completed cause of death MAN ISH A JARIWALA MC		Terrare	e Dr, l	walde	ufe	MD	206	02	
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			For State					nd Mental Hyg	_	1 1835
18 3	KE .	Ŷ.	State RegistrarAmend Item 1. Decedent's Name (First, Middle, Las	8 Per FH g	;854 4/1 <u>4</u>	eloughe of	Dealli	2. Date of Dea		3. Time of Death
	Physici		John Beryl M	avo				Month	23.2006	0700 AM
	, /Medio		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of [4c. County of Dea	
		A Specialists	Memorial H		de la la la la la la la la la la la la la		ton	Hrs. 8. Date of Birth	Talbot	
	Funeral Director			X M 2□F	In yrs. last birthda Yrs.	Months Days		Min. Min. Jul 29	Year) C	thplace (State or Foreign ountry)
7	ō.		214-38-6826 Usual Residence of Decedent					1001 25	12 10 TE	
	arylar show	_	10a. State 10b. County MD Carolin		Ridgel					10d. Inside City Limits 1 ☐ Yes 2 No
	the M	Director	MD Carolin 10e. Street and Number	е	Kiugei	10f, Zip Code			log. Citizen of What C	
	3a or	2	24199 Carrlyn Dri	W.O.		2166	0		U.S.	A .
	death	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 1			n? (Specify Yes or No- Puerto Rican, etc.)		erican Indian,
36	or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 No	Specify:	,	Specify: wh:	
21215-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show iteal Exac instructs be notified at	ed b	15. Decedent's Ed	Year or Dates: ucation	16a. De	cedent's Usual Occup	ation		16b. Kind of Business	
215	hin 72 an "na Madia	Completed	(Specify only highest gra	de completed) College (1-4or 5+)		ve kind of work done DO NOT use retire			Manufaatu	wing
2	ygiene ygiene ver tha	Con	12		m.	aterial sp		S L s Name (First, Middle,	Manufactu	LING
Maryland	t be fit ed oth ed oth	Be	17. Father's Name (First, Middle, Last)					nie F. Stat		
Ž	should nd Me mark mark	ဥ	Lloyd B. Mayo 19a. Informant's Name/Relationship (7)	Гуре, Print)	19b. Ma	ailing Address (Street		or Rural Route Number		Zip Code)
Ma	alth al		Mava Mayo / spou	se	241	99 Carrlyn	Drive	; Ridgely,	MD 21660	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Modical Exactinational be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Discemetery, of	sposition (Name of erematory or other pla	сө)	Date	20c. Location - City o.	r Town, State
ţ	tment tant: tant:		4 □ Donation 5 □ Other (Specify)	Greensb			27/2006	Greensboro	, MD
Bal	Depar Impor any ir		21. Signature of Enheral Service Licen	lugh			d Helfe Greens	enbein Fune sboro, Mary		1
9- #			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused the one cause on each line	he death. Do not	enter the mode of dy:	ng, such as ca	ardiac or respiratory arr	rest,	Approximate Interval Between Onset and Death
1000	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	consequence of):	aveino	na			6 months
	Examiner				corraequence or).					
100		Iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b. — Due to (or as a	consequence of):					
	ate be executed hysician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
760,	sician buria	ical E		d	, ,					
89	tificate ig phy as the									
Вох	eath certificat ettending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth 2	Fetal death	3 ∐Ectopic pregnanc	у		23d. Date of de Month	Day Year
	the el	ysici	1 Yes 2 No 9 Unknown	4□Pregnant at ti 9□Unknown	me of death	5 Other (specify)				,
, P.O	The law requires that the death certificate be executed the has been signed by the ettending physician and oage 2 should be detached for use as the burial-transit	by Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in th	e underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires been sigi should be	ed b						1 📉 Y	′es 2□No 3□F	Probably 4 Unknown
eco	taw re as be	Completed						24a. Was a autop	sy prior to	autopsy findings available completion of cause of
<u>~</u>		Con						perfor 1 ☐ Yes	med? death? 2.No 1 ☐ Ye	
Vita	Physician: rthis certifica ral director, I	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1X Inpatient	t 2 🗆 ER/Outpa	tient 3 DOA Ot		of Death <i>(Check only or</i> sing Home 5 - Resid		20(6)
0	g Physer this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day		e of 28c, Inju			ow injury occurred	ecny)
sion	Attending Processing of the funer by the funer	atio	1) Avatural 5 Pending investigation	1	700.7	M 10	Yes 2 N			
Division of Vital Records,	or Att after de Direct in by t	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm (Specify)	street, factory, office		28f. Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of niner: On the basis of e	examination and/o	eath occurred at the t r investigation, in my	ime, date and opinion, death	place, and due to the o occurred at the time, o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mailing state	,	29c. Licen	se number	1:	29d. Date signed (Mor	nth, Day, Year)
			1 Texx II	1 Shire	el	1)472	32	3/23,	12006
			30. Name and address of person who	·			THE STATE OF		1	
	is the stan		Mary S. DeShield: 31. Date filed (Month, Day, Year)	s; 509 Idle 32. Angistrar			MD 216	01		
	St Regist	ate rar	MAR 2 4 20	106	a B	franks				

				State							ental Hygi	_	ile.	
			1 - For State Registrar		J		rtificate					g. No.	6 11836	
			1. Decedent's Name (First, Middle	, Last)							2. Date of Death Month		3. Time of Death	
	Physicia /Medic		Ethe!	men	5.6							LP 20	06 1050 BM	
)	Examin		4a. Fecility Name (If not institution	, give street and n	umber)				Location o			4c. County of		
			5. Social Security Number	6. Sex	7. Age (In yrs.	(and historia)			If Under:		8. Date of Birth		5 genera	
	Funeral Director		202-20-4343	1 M 2 X F	7. Age (in yrs.	78 Yrs.	Months	Days	Hours	Min	(Month, Day, 02/20/19	Year)	9. Birthplace (State or Foreign Country) Ohio	
			Usual Residence of Decedent								02/20/1:	720	OHIO	_
	nylan ihow	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits	
	Ba-f s	Director		gomery	Ge	rmanto	-						1 ☐ Yes 2 🔯 No	_
	death with the Maryland me 23a or 28a-f show	Dire	10e. Street and Number				10f. Zip				10	g. Citizen of Wh		
	eath v	Funerai	20641 Shadysid		cedent Ever in U	10 12		0874		ain? (Sne	city Ves or No-	United	States - American Indian,	
	tter d	Fun	11. Marital Status 1 □ Never Married 2 □ Marri	Armed I	Forces?		If Yes, spec	ify Cuba	n, Mexican	, Puerto l	cify Yes or No- Rican, etc.)		, White, etc.	
2	urs a	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, C Year or	Sive		1 ☐ Yes	2⊠ No	Specify:			Specify:	White	
21215-0036	be filed within 72 hours after death with the Marylan at all typiene. I all typiene. I all typiene. I all the marker is a file in the continuation of the continuation at a continuation.	Completed	15. Decedent (Specify only highes	t's Education	d)	16a. Dece	dent's Usua	al Occupa	ation	t of workir	10	6b. Kind of Busi	iness/Industry	
7	ithin nen nen	mpie	Elementary/Secondary (0-12)	1	(1-4or 5+)		kind of wor					D : 11		
Z	iled w lygier her ti		12 17. Father's Name (First, Middle,	i act)		Sal	es As	soci		r's Name	(First, Middle, M	Retail		_
yiand	ould be fi Mental H larked ot latic ever	Ве	John Kazar	Lasi/								aluen Sumame)	,	
Ž	should bd Me mark imatic	2	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a		r Or Rura	l Route Number,	City or Town, SI	itate, Zip Code)	_
Z Z	nd 2 soluth ar 27 ls r trau		Jamie McNie /				•	'					land 20874	
ē,	s 1 er f Hee Item othe		20a. Method of Disposition		20b.	Place of Dispo cemetery, crea						·	City or Town, State	_
Ē	Page Int. If		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S _i		n State	Linco				4/3/	2006 I	Brentwoo	od, Maryland	
Baitimore,	permit. Pages 1 end 2 should be f Department of Heelin and Menial I Importent: If Item 27 is marked of any injury or other traumatic even once.		21. Signature of Funeral Service	Licensee		S 1	Name an	d Addres	s of Facilit	uner	al and (Crematio	on Center	
	g ∪ E ≅ 9		MUS.	4		μ0	40 Ro	ckvi	lle F	ike;	Rockvi.	lle, Mar	yland 20852	
			23a. Part1. Enter the disease, or shock, or deart failure. List	only one cause or	t caused the dea each line.	th. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death	
<u> </u>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a. 3~	umo									
	Examiner		3 =====,		o (or as a consec	quence of):								
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a consec	quence of):								-
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S										
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χ X	certificat Iding physise as th	Physician/Med	IF FEMALE:	230 If yes o	utcome of pregn	2004								_
X Q	death o	ian.	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 ☐ Feta gnant at time of a	aldeath 3	Ectopic pr					23d. Date Monti		
j.	the d y the iched	ysic	1 □ Yes ❤️♣No 9 □ Unknown	9□ Unk		304(1)	2 0 1101 (3)							
S, T	requires that een signed b hould be deta	by Pt	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob	acco use contrib	oute to the cause of death?	
Cords	quire an sig ruld b	edb	Disperser 0	10/1: tu	5 770	- TP					1 ☐ Ye	s 2€ No 3	B ☐ Probably 4 ☐ Unknown	
ပ္ပ	lawre as bee 2 sho	piet	Dys/: orlania								24a. Was an	24b. We	ere autopsy findings available ior to completion of cause of	
ř	The ate h page	Completed	912 homen	net a	very: «						perform	ed? de	eath? ☐ Yes 2☐ No	
ıraı	sician: The law cartificate has t irector, page 2 s	Be (25. Was case referred to medical examiner?					100		of Death	(Check only one)		_
6	Physi this c	. To	1 ☐ Yes 22 No 27. Manner of Death			ER/Outpatier			A-LI NU		ne 5 Resider			_
5	ding h. After funer	tion	Natural 5 ☐ Pendin	9	e of Injury onth, Day Year)	Injury	M	8c. Injury Work	γαι (? Yes 2.∐l		ed. Describe no	w injury occurred	u	
DIVISION	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could i	not be 28e. Pla	ce of Injury - At h	ome, farm, str							r or Rural Route Number,	_
S	el or s s after il Dire	Certification:	4 ☐ Homicide determ	bui	lding, etc. (Speci	(y)					City or Town,	State)		
	To the Hospitel or Attending Physician: within 42 hours atter death: To the Funeral Director: Aller this cartification or property filled in by the funeral director;		29a. Certifier & Certifyin	g Physician: To the	he best of my kn	owledge, deat	h occurred	at the tim	ne, date an	d place, a	and due to the ca	use(s) and manr	ner as stated. Ind due to the cause(s)	_
	the H nin 24 the F nplete	Medical	one)	and ma	anner stated.	ation and of in				(ii occurre			<u>ii</u>	
ı	with Con	2	29b. Signature and title of certifier	Two Dank	Carl si		and the same of	: License	number	ч	29	a. Date signed ((Month, Day, Year)	
•				1		- 00. 1 ==			,06	\		2/22/3	wi.	
	3		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)	Ties on	.60	Jog .	Św.	Row	Ch, allux	
ŧ	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sign	ature	- 1	801	- Ser. 6	AC 26	1000 g	7	201	
	Registr		MAR 31	2006	Registrar's Sign	y Ago	nes!							
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			. For		State of M		d / Depa					-		_	•	101	m, mm
			1 - State Registrar					tificate					Reg. N	7 11115		18	3 /
	Physici	an	Decedent's Name (First, Midd	6			21 -		0		-	2. Date of Do Month	Da		r	3. Time of D	
	/Medic	cal	4a. Facility Name (If not institution		andor	7 8	Mai			Location of		mar		County of Pe	W.2	2126	M
	Examir		montgomery	1	en No	50		10. Oily,	1	المالية المالية	n Death			10mf	1	nery	,
	Funeral		5. Social Security Number none	6. Sex		_	last birthday) Yrs.	If Under Months	,	Hours	24 Hrs. Min.	8. Date of Bi	rth	- J	irthplac	eru	Foreign
*	Director		Usual Residence of Decedent				113.					APILI		,,,,,,,,,		eru	
	arylan show dat	_	10a. State 10b. County MD Mont		lorv	1	y, Town or Lo Rockvi								10d	. Inside City	
	he Ma 88e-1	ecto		90111	y	1	COCKVI									1 🗌 Yes 2	
	72 hours after death with the Maryland Instural; or Itema 23a or 28e-f ehow dical Examiner must be notified at	Funeral Director	10e. Street and Number 5021 Aspen	Hil	l Road			10f. Zip	208	53	-			itizen of What Peru	Country	/ {	
	death	nera	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spec	cify Yes or N Rican, etc.)	0-	14. Race - Ar			
36	s after , or ite	by Fu	1 Never Married 2 Mar		1 ☐ Yes 2 🐼 I If Yes, Give	No		XYes 2				ticari, otc.,		Black, W Specify:		nite	
21215-0036	72 hours natural',	ed p	3 ☐ Widowed 4 ☐ Divorce		Year or Dates:		16a Decer	fent's Usua	LOccupa	tion			16b h	Kind of Busine			
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7	filed wit Hygiene ther the	Соп	12		3. (,	Main	tena	nce				1	leani	ng	Co.	
Maryland	d fall	Be	17. Father's Name (First, Middle Joaquim San		ĺ							(First, Middle a Mar					
Z	2 should and Mer is marke	2	19a. Informant's Name/Relation				19b. Mailir	g Address	(Street a					or Town, State	, Zip Co	ode)	
	12 and		Javier Sand	on/	Son			1 As						ville			53
Baltimore,	of He and		20a. Method of Disposition 1 Burial 2 Cremation	3 □B	Removal from State		lace of Dispo emetery, cren	sition (Nam natory or ot	ne of ther place	9)	Da	ate		ocation - City			
ţi	tment of the line		4 □ Donation 5 □ Other (Specity)),	Ch	esape							ltsvi		·	
Bal	permit. Departr Importa eny inj		21. Signature of Funeral Service	Ligense			P	HTET	PAddles Call	RIN	ALDI	FUNE	RAL	SERV	ICE	, P.A.	
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r compli	ications that caused	the deat	h. Do not ent	er the mode	of dying	g, such as	cardiac or	respiratory a	TVE	r Spr	A	pproximate	
Sec.	Physician		Immediate Cause (Final disease or condition	t only or	S . L	ne.	06-	1	1	mo	/			10		nset and De	
	/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):	70	116	mo	· y / //	1			27	16	
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<	230 10,101 43	u 5511554	301130 01).										
oʻ	be executed sicien and burial-transit	Exa	resulting in death) Last	1	Due to (or as	a conseq	uence of):										
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89 x	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE:	2	3c. If yes, outcome	of pregna	incv							22d Data of	(alixanı		
Box	death e atter d for u	iclar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No		1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	death 3	Ectopic pre Other (spe						23d. Date of d Month	Da	ay Ye	ar
P.0	at the	hys	9 🗆 Unknown		9 Unknown												
Vital Records,	es pe	þ	Part II. Other significant condit	ons con	ntributing to death b	ut not res	ulting in the ur	nderlying ca	iuse give	n in Part I.				use contribute		1	
CO	aw requir is been s 2 should	Completed										24a. Was				findings av	
		E O										auto perfe	psy ormod? 22 No	death	o comp ? 9s 2[letion of cau]] No	ISO OT
Vita	Phyeicien: Th this certificete ral director, pag	Be	25. Was case referred to medica examiner?	· -	lospital:				Oth		of Death	(Check only					
of	Phye	To To	Yes 2 No 27. Manner of Death		28a. Date of Inju	ry	€R/Outpatien 28b. Time of		A Othe Bc. Injury Work	4 🗆 140		ne 5 Res 8d. Describe		6 Other (S)	pecify)		
ion	Attending F r death. ector: After by the funera	atlor	1 Natural 5 Pendi 2 Accident invest	ng igation	(Month, Da	y Year)	Injury	М		:? /es 2 □!			,	,			
Division	in the c	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern		28e. Place of Inj building, et			eet, factory,	office		2	8f. Location (City or To	Street a	nd Number or e)	Rural R	oute Numbe	er,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in		La. Certifier 1 Certifyi	ng Phys	sician: To the best	of my kno	wledge, death	occurred a	at the tim	e, date an	d place, a	nd due to the	cause(s	and manner	as state	ed.	
	the Ho nin 24 the Fu	Medical	one)		ner: On the pasis of and manner sta	examina ated.	tion and/or inv				h occurre	d at the time,					
	T with	Σ	29b. Signature and title of certiful		. V.			1		number				ate signed (Mo			
,	4		30. Name and address of person	who en	moleted cause of d	eath (Item	23a) (Tune	Print) 5	100	172	Oder	00	e. E	= O(<c< td=""><th>000</th><td>2</td></c<>	000	2
_			IRA NB	RE	CHER.	mo	oms	5	10	c1)	pri	ng Y	no	209	701		
	Sta Registr		31. Date filed (Month, Day, Year MAR 3		32 Gegistr	ar's Signa	F Ap	arte) .			209			

Registrar

		1 - For State Registrar	State of N	Marylar				lealth Death			Reg. N	HHA	839
Physic	ian	1. Decedent's Name (First, Middle, I	Last)							2. Date of D Month	Da	ay Year	3. Time of Death
/Med	ical	Harold			Ewen	41: 01:	T	1		March :		2006	2:07 PM
Exami	iner	4a. Facility Name (If not institution, g CASEY HOUSE	nve street and numbe	er)		40. City		r Location ROCKV			40	c. County of Dea	
Funeral			. Sex 7	Age (In yrs.	last birthday	If Unde	r 1 Year			8. Date of Bi	rth		NTGOMERY
Director		095-09-1917 Usual Residence of Decedent	1⊠M 2□F	97	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 10/22/	ay, Year L908) C	rthplace (State or Foreign country) N . Y .
5-UU36 72 hours after death with the Maryland natural', or Items 23a or 28a-f show acal Exeminer must be notified at		10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Limits
Mar B-fet	tor	MARYLAND MC	NTGOMERY			SI	LVER	SPRI	NG				1X Yes 2 □ No
or 28	Funeral Director	10e. Street and Number					p Code				10g. C	itizen of What C	ountry?
ath w	rai	11425 FAIROAK DR	IVE					209				U	.S.A.
er de	une	11. Marital Status	12. Was Decede Armed Force	ş?	J.S. 13.	Was Dece If Yes, spe	dent of F orify Cub	lispanic Or an, Mexicai	igin? (Spe n, Puerto l	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	
rs aft	by F	1 Never Married 2 Married 3 ₩ Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 🗌 Yes	2 X] No	Specify:				Specify:	WHITE
d it is 15-0050 A within 72 hours after death with the Marylan plene. I than "natural", or Iteme 23a or 28a-f ehow the Madical Examinar must be notified at	ed	15. Decedent's	Education		16a. Dece	dent's Usi	al Occur	pation			16b. l	Kind of Business	s/Industry
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y idil buld be Menta arked atic ev	10	FRED	McEWEN	N				EMMA				MF	EADE
os t and 2 should be filled of Health and Mental Hy fitem 27 is marked other other traumatic events		19a. Informant's Name/Relationship								l Route Numb	er, City	or Town, State,	Zip Code)
		NANCY McEWEN/DAU	GHTER	205				DRIV					RYLAND 20902
permit. Pages 1 a Department of Hee Important: If Item any injury or othe	4	20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te C	Place of Dispersion of Dispers	matory or	other plac	· 1	03/2	6/06		ocation - City or	
mit. 9 partm portar inju		21. Signature of Funeral 3 rvice Lic		11211	1 2	2. Name a	nd Addre	ss of Facili	ty				H, VIRGINIA
Depa Depa Impo		1 Anoth	ン		E	DWARI 091	SA(GEL FI	UNERA	L DIRE	CTIC	ON, INC.	LAND 20852
Physician /Medical	÷ ();	23a. Part 1. Enter the disease, or oc shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each	ı line.	th. Do not en	ter the mo	de of dyir	ng, such as	cardiac o	r respiratory a	rrest,	1 12 11 1	Approximate Interval Between Onset and Death
sate be executed whysician and the burial-transit	ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	аз а сопз в у as a conseq									
death certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	I death 3	Ectopic p		′			# - 188	23d. Date of de Month	livery Day Year
law requires that the as been signed by the 2 should be detached.	þ	Part II. Dther significant conditions	contributing to death	but not res	ulting in the u	ndertying	cause giv	en in Part I					o the cause of death? robably 4 ∐Unknown
The law rester has be page 2 sho	Completed						 _			24a. Was auto perfe	psy ormed?	prior to death?	utopsy findings available completion of cause of
ician sertifii ector.	Be	25. Was case referred to medical examiner?	Manaital				T ou			Check only			
Attending Physician: The reference of th	tion: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	Hospital: 1 Inpa 28a. Date of Ir (Month, L		ER/Outpatier 28b. Time o Injury		28c. Injur Wor	4 🗆 140	2	ne 5 Resi			HOSPICE
in the interior	Certification:	3 Suicide 6 Could not determine	be 28e. Place of I	Injury - At ho etc. (Specif	ome, farm, str	eet, factor	y, office		2	8f. Location (City or To			ural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying I 2 Medical Expone)	hysician: To the beaminer: On the basis and manner	or examina	wiedge, deat tion and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	id place, a ith occurre	and due to the ad at the time,	cause(s date an	and manner as d place, and due	s stated. e to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier		~ 1		29	c. Licens	e number			29d. Da	ate signed (Mon	th, Day, Year)
Ц					,		D356	35			MAR	CH 23, 2	2006
-1		30. Name and address of person wh				,	n -	0.0					
C.	ate	DR. JOSEPH KAPLAN 31. Date filed (Month, Day, Year)	32. Regis	NCASTE strar's Signa	ture			OCKVI	LLE,	MARYLA	ND_	20855	
Regist		31. Date filed (Month, Day, Year)	2006	Wed I		raver	•						

	_1	For State Registrer	State of Marylar		artment of trificate of			ental H	ygiei Reg.	211	6	1840
Dhycicia		1. Decedent's Name (First, Middle, Last)						Date of I Month		Day	Year	3. Time of Death
Physiciai /Medica		Frederick	Louis	Мс	Coy	Jr		March	22.	2006		8:00P M
Examine	r '	la. Facility Name (If not institution, give s			4b. City, Town,		of Death			4c. County	of Death	
		Holy Cross Hospita			Silver					lontgo		
Funeral	1	5. Social Security Number 6. Sex	M 2FF	. last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of l	Day, Ye		Cor	place (State or Foreign intry)
Director	-	220 40 4535 Usual Residence of Decedent	63	110.		1		June	16 1	942	Wash	ington, D.
land ow	-	10a. State 10b. County	10c. C	ity, Town or Lo	cation							10d. Inside City Limits
Mary	ġ,	Maryland Montgome	C.i	lver S	nadas							1 ☐ Yes 2 → No
the	9	10e. Street and Number	<u>:1 y </u>	TAGE 2	10f. Zip Code				10g.	Citizen of V	Vhat Cou	intry?
h witt	2	200 Farmgate Lane			20	905				US	A	
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at other.	Funeral Director		Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of f Yes, specify Cul		rigin? (Spec	ofy Yes or	No-	14. Rac	e - Amer	ican Indian,
after a		1 ☐ Never Married 2 ☐ Married	1 Yes 2 No		1 ☐ Yes 2 🛣 No			iicaii, eic.)			k, White	-
ours ours	o n	3 Widowed 4 Divorced	Year or Dates:		103 2010	- Openin				Specify	WII	ite
72 h	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	tent's Usual Occu kind of work done	during mo:	st of workin	g	16b	. Kind of Bu	isiness/li	ndustry
Athin Mithin	<u> </u>	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	9d)						
lied v tygie tygie thert	S	17. Father's Name (First, Middle, Last)	5 +	Econ	omist	18 Moth	ner's Name	/Eirst Midd		count		Firm
od ot a series	ă		0								0)	
Mer d Mer	2	Frederick Louis Mo 19a. Informant's Name/Relationship (Type		10h Mailir	ng Address (Stree		zabeth				State 7	in Code)
VICE ST 12 ST 14 ST 15 IS IN TITE UIT TRAUM		Lois Diane McCoy			armgate							
Heelt ther	-	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	1		ate		. Location -		
2 8 1 2 3 X		1 Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, crer	natory or other pla							
mit. Pages partment of portant: If it y injury or ce.	-	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Vicense	/ / /		Mem Par			/2006	Ro	ckvil	le,	Maryland
Dani Departiment Department of the part is any is		21. Signature of Fulleral Service Literas	Jan ba	i	. Name and Addr							
	+	23a Part1. Enter the disease, or complic	cations that caused the dea							er sp	ring	MD 20904 Approximate
		shock of heart failure. List only on	e cause on each line.			ing, such as	s cardiac or	respiratory	arrest,			Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	End Stage)isease							
/Medical Examiner		()	Due to (or as a conse									
	_	Sequentially list conditions,	Dibetes Me									
pet led	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hypertensi									
xecu n and al-tra	Xar	that initiated events c resulting in death) Last	Due to (or as a conse									
cate be executed physicien and the burial-transit	dicai											
icate iphy: s the												
The law requires that the death certificate be executed the best been signed by the ettending physicien and page 2 should be deteched for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn							23d. Dat	e of deliv	very
death ette	200	in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnand Other (specify) _	СУ			_	Mo		Day Year
the o	S	9 Unknown	9□ Unknown									
that that ded b		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause g	ven in Part	1.	23e. Di	d tobacc	co use conti	ibute to	the cause of death?
uries ti	o D							1[Yes	2 🗆 No	3 🖺 Pro	bably 4 🙀 Unknown
w requires that is been signed to should be determined to the state of	e							24a. W	as an	24b. V	Vere aut	opsy findings available
he la he sage 2	Completed							au	topsy normed 2	? 5	leath?	ompletion of cause of
P : T : T		25. Was case referred to medical				26 Plac	e of Death			No 1	∐ Yes	2 No
s cert	0	examiner?	ospital: 1X Inpatient 2] ER/Outpatier	t 3 DOA	har	lursing Hom			6 []Oth	ar (Snac	(fu)
Phy Practical Control	- +	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of						njury occurr		77
Attending or death. ector: Afte by the fune	9110	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 19ar)	Injury		onk? ∐Yes 2.∐]No					
Atte	2	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Injury - At h	nome, farm, str	eet, factory, office		2		(Street Town, St		er or Rui	al Route Number,
S effective of the part of the	Certification:	realised	building, etc. (Speci	·· * /				July Of 1	JMII, JI	10/		
		29a. Certifier 1 Certifying Phys	icien: To the best of my kn	owledge, deatl	occurred at the	ime, date a	nd place, ar	nd due to th	ne cause	e(s) and ma	nner as	stated.
he H in 24 he Fi	Medical	one)	er: On the basis of examin and manner stated.	ation and/or in	vestigation, in my	ориноп, де	atn occurre	u at the tim	e, date	and place, a	and due	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	1) -			se number						, Day, Year)
		> We cold	ela		D00	62520			Mar	ch 23	, 20	06
15		30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type,	Print)							
12		Maria D'Arbella,	M.D. 1500 Fo	rest G	en Road	Silve	er Spr	ing,	Mar	yland	209	02
State	-	31. Date filed (Month, Day, Year)	32. Registrar's Sign	- 4				151				
Registra	î	MAR 2 7 20	JUD Degues	15. 68	DEPEK.							

			1 - For Stete Registrer	State of I	Marylan		artmen rtificate				lental Hyg	giene Reg. No.	006	8
	Dhusia		Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physica /Medi		Joan Burdick M	lcCabe							March 2	_	2006	6:20 P M
	Examir	er	4a. Facility Name (If not institution,	_			4b. City,	Town, or	Location	of Death		4c.	County of Deat	h
		100	Montgomery Gen		****		Oln			0411			ontgome:	
2	Funeral Director		5. Social Security Number 220-60-6548	6. Sex 7. 1 ☐ M 2X F	Age (In yrs. 51	last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Birth (Month, Day Feb. 1,	v, Year)		hplace (State or Foreign untry) yland
1	pud &		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Aaryla sho	ō												1X Yes 2 No
	28a-1	ect	MD Montgo	mery	G	aither	sburg 10f. Zip	Code				10a Citiz	en of What Co	untry?
	with	ā	103 Dogwood Dr	1110				877						and,
	Jeath ms 2	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U.	.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	USA	4. Race - Ame	rican Indian,
(0	riter	Fun	1 ☐ Never Married 2 🕱 Marrie	Armed Force							Rican, etc.)		Black, White	e, etc.
93	al', d	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes	2A No	Specify:				Specify: Wh	ite
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28s-f show Jisal Execult writtual be inclified at	Completed	15. Decedent's (Specify only highest	s Education		16a. Dece	dent's Usua kind of wor	al Occupa	ation during mos	t of work	ina	16b. Kir	nd of Business/	Industry
2	within ene.	npie	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT us	se retired)					
	be filed within 72 hours after death with the Marylan lat Hygiene. d other then "natural", or Items 23a or 28a-f show event, I'm Mexilest Exacult at mart te rictified at			4		Grap	hic A	rtis		4 11			rtising	9
pur	be fi hair H od otl	Be	17. Father's Name (First, Middle, L						18. Mothe	er's Name	First, Middle,	Maiden :	Surname)	
풀	should be filed valued Mental Hygie marked other lumatic event, It	²	Ralph S. Bur			105 14-15		(01			Felica			Tio Code)
Maryland	permit. Pages I and 2 should be Department of Health and Menta Important: if Itam 27 is marked any Injury or other traumatic er ODGS.		19a. Informant's Name/Relationsh Daniel Owen McC		nd	1					al Route Numbe			
	1 an Heall am 2		20a. Method of Disposition	abe/ nusba	20b. P	lace of Dispo	sition (Nan	ne of			thersbu		MD 208 ation - City or	
nor	nt of nt of tr. if it		1 Burial 2 Cremation		110	emetery, crei	•		1	N.S	25 2005			
Baltimore,	artme prtani Injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signatuse of Funeral Service L		reur	opolitar 2	Name an	d Addres	s of Facilit	hv	25, 2005		andria, \	VA
Ba	Deparential Depare		I Ash Coller	s Mystel	<u> </u>	_ F:	rancis	J. C	ollins	Fune:	ral Home,	Inc.		
	100		23a. Part1. Enter the disease, or o	complications that cause	sed the deatl						st, Silve		ing, MD	Approximate
	Dhysisian		shock, or heart failure. List o Immediate Cause (Final	nly one cause on each	n line.	101	l d o l							Interval Between Onset and Death
*	Physician /Medical		disease or condition resulting in death)	a	as a conseq	uence of):	na							
	Examiner													
		je	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or	as a cons	uence of):								
	cuted	Examin	Cause (Disease or injury that initiated events	c.										
Ö,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):								
8760,	ate b hysic the b	licai	,	đ									-	
, Q	death certificat e attending phy od for use as th	Physician/Med	IF FEMALE:		0.0000									
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor	2 Feta	Ideath 3	Ectopic pr					2	3d. Date of deli Month	ivery Day Year
0	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnani 9□Unknowr		eath 5	Other (sp	өсту)						
О.	that the de led by the a deteched f		Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	bacco us	se contribute to	the cause of death?
Records,	8 5 9	d by									1 🗆 Y	'es 2[ONo 3□Pr	obably 4 Hiknown
200	w require been sig should b	Completed									24a. Was :	an	24h Were au	itopsy findings available
Re	0 = 0	E G									autop	sy med?	prior to death?	completion of cause of
Vital	ician: Th certificate rector, pag	e C	25. Was case referred to medical						26 Place	of Doot	1 ☐ Yes	2	1 ☐ Yes	200
>		To B	examiner? 1 ☐ Yes 2 2 No	Hospital:	atient 2	ER/Outpatier	nt 3 DC	Othe	25.		me 5 Resid		Other /Sne	cuful.
1 of	g Physier this		27. Manner of Death	28a. Date of I		28b. Time o		8c. Injury Work			28d. Describe h			y /
ior	Attending ir death. ector: After by the fune	atio	Natural 5 Pending 2 Accident investigation	ation	Day (Gai)	Injury	М		Yes 2	No				
Division	after death after death Director:	Certification:	3 Suicide 6 Could no 4 Homicide determine	286. Place of	Injury - At ho	ome, farm, str	eet, factory	, office			28f. Location (S City or Tow			iral Route Number,
	ital or rs afte rel Dir led in l	Cer												
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	29a. Certifier Certifying (Check only one)	Physicien: To the be xeminer: On the basis and manner	s of examina	wledge, deat tion and/or in	h occurred vestigation,	at the tim , in my of	ne, date an pinion, dea	id place, ith occurr	and due to the d ed at the time, d	ause(s) : date and	and manner as place, and due	stated. to the cause(s)
	within To th compl	Me	29b. Signature and title of gentifier				290	. License	number		-	29d. Day	signed (Monti	h, Day, Year)
			► (IVIVAY DA	M. M.	b		7	200	163	160	1	3/	23/0	6
-	سي		30. Name and address of person w	no completed cause of	of death (Item	1 23a) (Type,	Print)	1 1	· · ·			-		
_	5		Matthew McAV	d rew	1810		MOP	Phili	1 Dr	WF	Olive	4,	HD 6	208-32
1000	Sta		31. Date filed (Month, Day, Year) MAR 2 7		istrar's Signa	iture	-		1	, -		17		
*	Regist	rar	MAR 2 7	2006	we 1	5. Pop	ands)							

			1 State	Maryland / Depa <i>Ce</i>	artment of He <i>rtificate of D</i>			2006	11842
			Registrar 1. Decedent's Name (First, Middle, Last)		· imrodito oi D		2. Date of Death		3. Time of Death
	Physici /Medic		ALICE N	ARGARET MCD	ADE		Month March	24, 2006	5:20 A M
	Examin		4a. Facility Name (If not institution, give street and numb		4b. City, Town, or Le			4c. County of Dear	th
			Copper Ridge Nursing Home 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	Sykesvil	Le If Under 24 Hrs.	8. Date of Birth	Carroll	holace (State or Foreign
	Funeral Director		218-34-3525 ¹ X ^M ² F	89 Yrs.		Hours Min.	(Month, Day, 1	1916 Mar	hplace <i>(Stat</i> e or Foreign buntry) y land
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	or death with the Marylan Items 23e or 28a-f show	ctor	Maryland Carroll	Sykesvil	le.				1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23e		710 Obrecht Road		21784			U.S.A	
30	within 72 hours affer death with the Maryland ene. than "naturel", or Items 23e or 28e-1 show in Medical Evair and must be a suffice and in Medical Evair and must be a suffice and in Medical Evair and must be a suffice and in Medical Evair and must be a suffice and in Medical Evair and must be a suffice and must be a sufficient an	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 □ If Yes, Give Year or Date	No	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 XNo	nanic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
215-0036	72 hours "naturel",	ted b	15. Decedent's Education	16a. Dece	dent's Usual Occupation	on	10	6b. Kind of Business	
7	be filed within 72 hours affer la! Hygiene. d othar than "naturel", or I avant. " Nedical Eram	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	or 5+) life.	kind of work done dur DO NOT use retired)	ang most of worki	ng		
7	filed w Hygier othar th		12 17. Father's Name (First, Middle, Last)	H	omemaker	R Mothor's Name	(First, Middle, Mi	Own Home	
and		o Be	Harry D. Axline		, ''		ne Hende		
\geq	d 2 should th and Men 7 is marke traumatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and				Zip Code)
Mar.	d 2 7 is		Kathleen Bartgis / Sister	1330	2 Old Anna	polis Ro	ad, Mt.	Airy, MD	21771
Baltimore,	itar ott		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cre Union Ce	osition (Name of matory or other place) metery	3/27/		oc. Location - City or rkittsvil	Town, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signal re di Funeral Service Licensee	2. R	2 Name and Address OBERT E. D. 201 NORTH	of Facility AILEY &	SON FUNE	RAL HOMES	, P.A.
			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not en	ter the mode of dying,	such as cardiac c	r respiratory arres	it,	Approximate Interval Between
	Physician	į.	Immediate Cause (Final disease or condition	zhz.mzis	Der	nantin			Onset and Death
	/Medical Examiner		resulting in death) Due to (or	as a consequence of):					
Ü		Jer	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):					
	cuted nd ransif	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.						
Ď,	iificafe be executed g physician and as fhe burial-transif	EX	resulting in death) Last Due to (or	as a consequence of):					
P8/P0	physic	edlcal	d						
O. BOX	af the death certific by the atfending p tached for use as	Physiclan/Me		n 2 Fetal death 3 tat time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	ivery Day Year
٠ <u>.</u>	res thaf f igned by be deta	by Ph	Part II. Other significant conditions contributing to deat	h but not resulting in the u	ınderlying cause given	in Part I.	23e. Did toba	cco use contribute to	the cause of death?
cords,	w require: been sig should be						1 🗆 Yes	2 2 1 √0 3 □ Pr	obably 4 Unknown
T T	e la has	Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
VII	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				(Check only one,		
010	Physic this or	70	1 Yes 2 No Hospital: 1 Inp			4 Privatsing nor		ce 6 □Other (Spe	city)
	ding F h. After funer	tlon	1 Natural 5 Pending (Month,	njury 28b. Time o Day Year) Injury	Work?	s 2 No	28d. Describe how	injury occurred	
DIVISION	Attan deat ctor: y the	Certification:	3 Suicide 6 Could not be	Injury - At home, farm, st etc. (Specify)			28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospitel or within 24 hours affer To the Funeral Directory (illed in b	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the basi and mannel and mannel	s of examination and/or in	th occurred at the time, ovestigation, in my opin	date and place, a ion, death occurre	and due to the cau ed at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within To the comple	Me	70h. Signature and title of contifier		29c. License n	number	290	d. Date signed (Mont	h, Day, Year)
			I have I Mon	-,	DJ	. V L		2/27/	96
		1025	30. Name and address of person who completed cause of Part of the Mark 2 9 2006 MAR 2 9 2006	of death (Item 23a) (Type.	Print) C+	L. U.	Res	forten,	ML
	Sta Registr	të ar	MAR 2 9 2006	istrar's Signature	parti				

			1 - State Registrar	ate of Mar	yland / Depa <i>Cei</i>	artment rtificate			ind M	Re	g. No.	06	11843
40%	Physici	an "	Decedent's Name (First, Middle, Last)							2. Date of Death Month	Day	Year	3. Time of Death
3	/Medic				n Miller					March	31	2006	7:55 ₽ ^M
7	Examir	er	4a. Facility Name (If not institution, give stree					Location o				ty of Death	
			9118 Northfield Road 5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1		tt Ci		9 Date of Birth		ard	ace (State or Foreign
, e.:	Funeral Director		253 68 8028		Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Dec 13,	^{Year)} 1944	Coun	rgia
			Usual Residence of Decedent							Dec 15,	1944	GCO	Lyıa
	anylan show	_	10a. State 10b. County	1	Oc. City, Town or Lo	cation						11	Od. Inside City Limits
	ith the Marylar or 28e-f show	ecto	MD Howard		Ellicott								1 ☐ Yes 2 ☑ No
	with ti	直	10e. Street and Number	,		10f. Zip (10		f What Coun	•
	s 234	Funeral Director	9118 Northfield Road	l /as Decedent Ev	er in 11 S 13 1		1042	spanic Orig	nin2 (Sn	acify Vas or No-		d Stat	
10	fter d	Fun	A	med Forces? ☐ Yes 2€ No	ŀ			n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		ack, White,	
036	ol', o	by		Yes, Give ear or Dates:		1□Yes 🏖	☑ No	Specify:			Spec		nite
21215-0036	within 72 hours after death with the Maryland sne. than "naturel", or Items 23e or 28e-f show the Medical Examiter rust be ricillized at	Completed	15. Decedent's Educatio (Specify only highest grade con		(Give	dent's Usual kind of work	k done di	urina most	of work	ina 1	6b. Kind of	Business/Inc	lustry
21	han .	mpf	Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. I	DO NOT use	e retired)	3			_		
	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)	5+	Tead	cher		18 Mothe	r's Name	e (First, Middle, M		ation	
Maryland	d in b	Be c	James Dixon							ı Willian		ino)	
7	2 should and Men is marke sumatic	2	19a. Informant's Name/Relationship (Type, F	rint)	19b. Mailir	ng Address	(Street a			al Route Number,		n, State, Zip	Code)
	nd 2 :		David L. Miller/Hush	pand						llicott			55-3
ē,	of Health item 27 i	- 1	20a. Method of Disposition		20b. Place of Dispo						-	- City or To	
Ë	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 14 ☐ Donation 5 ☐ Other (Specify)	val from State	Sunset Me	_	_	1	-8-2	2006 A	meric	us, Ge	oruia
Baltimore,	arthur inju		21. Signature of Funeral Service Licensee	na I	M01044 22	. Name and	Addres				tzke'	s Fami	ly FH Inc.
0	Dep Imp		New Collis !	the	41	112 01	d Co	olumb	ia F	ike Elli	.cott	City,	MD 21043
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	MckesTA	to death. Do not entract the Symbol S	er the mode	. 11 /			CLIZ	st,		Approximate Interval Between Onset and Death Món W
,760,	ate be executed hysicien and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	•	consequence of):								
687	physic	dical	d					-	-				
.O. Box	v requires that the death certifica been signed by the attending ph should be detached for use as th	by Physician/Med	in the past 12 months?	yes, outcome of Live birth 2 Pregnant at tir	Fetal death 3]Ectopic pre] Other (spe						ate of delive	ry Day Year
0.	s that ned b e deta	y Pt	Part II. Other significant conditions contribu	ting to death but	not resulting in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use co	ntribute to th	e cause of death?
rds	w require been sig should b	edk								1,XYe:	s 2□No	3 Prob	abiy 4 Unknown
Il Records,	The lav ate has page 2	Completed								24a. Was an autopsy perform	,	. Were autop prior to con death? 1 \(\sum \text{Yes}	osy findings available inpletion of cause of 2 \hat{1}{2} No
Vital	Physicien: this certific ral director.	Be	25. Was case referred to medical examiner?	al:			Othe	r		(Check only one	_	-	
of	Phys this ral dir	. To	1 193 2 140	a. Date of Injury	2 ER/Outpatien		`	4 🗀 INUI		me 5X Resider 28d. Describe how			"
o	ding h. After funer	ton	1 XNatural 5 ☐ Pending	(Month, Day		M	Bc. Injury Work	? ′es 2 ⊡ N		200. Describe not	w inquiry occi	31160	
Division	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be	e. Place of Injury	- At home, farm, str					28f. Location (Str	eet and Nun	nber or Rura	Route Number,
D.	after after	ert	4 Homicide	building, etc.	(Specify)					City or Town,	State)		
	To the Hospitel or Attending Is within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	Medical Certification;	29a. Certifier (Check only one) Certifying Physicia 2 Medical Examiner:	n: To the best of On the basis of eand manner state	xamination and/or inv	occurred a vestigation,	it the time in my op	e, date and inion, deat	d place, h occurr	and due to the car ed at the time, da	use(s) and r te and place	nanner as st , and due to	ated. the cause(s)
	To the To the complex	Σ	29b. Signature and title of certifier Ni chokus Inf. / 10	relule !	f _	29c.	License	number	7	29	•	led (Month, L	
<u>ه</u>	T		30. Name and address of person who complete the Roll of Roll o	Heliele	5mo 110	Print) 65 Li	44K	Pas	feer	ent Pky	Colu	ubin.	, MD 21044
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 3 2006	32. Registrar	s Signature	fac. V	D						
-		004	00 2000			The Contract of the Contract o	<i>FI</i>						

06-02379	
Olsen, David	

Physicia Medical Examin

Funeral

Director

any

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, MD 21215-0036

	Please Type o	r Print in	Black I	ndel	ible Ink				
	State of Maryland / Dep		f Health			Hygiene	2	006	184
_	Registrar	or unicate of	Dealli				Reg No.		
\ 	1. Decedent's Name (First, Middle,Last)					Date of Month	_	Y ear	3. Time of Death
-	David Owen Olsen					April 6	, 2006		20:25
	Facility Name (if not institution, give street and number) Anne Arundel Medical Center		4b. City, Tov Annapo		cation of Dea	th		ty of Death Arundel	
	5 Social Security Number 6. Sex 7. Age (In yrs	last birthday)	If Under	Year	If Under 24H	rs. 8. Date o	of Birth (MM/DD/YY		thplace (State or Foreign
	144-54-8748 1XM 2_F 45	Yrs	Months i.	Days	Hours M	n. 01/2	20/1961	Ne Ne	ew York
	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Locat	ion						404 (
			1011						10d. Inside City Limits
3	-	Arnold							1 Yes 2 X No
i L	10e Street and Number		10f. Zip Co				10g. Citizen of	What Cou	ntry?
5	780 Canvasback Ct.		2	2101	2		USA		
y runeral	11. Marital Status 1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced of Dates:	If Y		Cuban, M	inic Origin? (§ Mexican, Puert specify:		Wh	ice - Ameri nite, etc.	ican Indian, Black, .te
2	15. Decedent's Education (Specify only highest grade completed)	16a, Deceden	t's Usual Oc	cupatio	(Give kind of	work done	16b. Kind of I	Business/I	Industry
אבוב	Elementary/Secondary (0-12) College (1-4 or 5+) 5+		working life. Husba	_	Γ use retired)		Home	_	
5	17. Father's Name (First, Middle, Last)	HOUDE	ilabbe		Mother's Nam	e (First Midd	lle, Maioeri Surnan		
Ņ	Kenneth N. Olsen						race Such		
5	19a. Informant's Name/Relationship (Type, Print)	19b Mailing	Address (Street a			Number, City or To		Zin Code)
	Denise Eng Olsen/ Wife						d, MD 210		; 2ip 00de)
	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	Place of Dispos crematory or oth Kalas Cr	ition (Name on her place) emator	of ceme	tery, 4—	Date 10–06	20c. Location Edgev	n - City or water	, MD
	21. Signature of Funeral Service Licensee	29	73 Sol	omo.	ns Isla	and Rd	P. Kalas . Edgewat	ter,	
	23a Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line.	h. Do not enter th	ne mode of d	ying, su	ch as cardiac	or respiratory	arrest, shock, or h	neart	Approximate Interval Between Onset and
	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Due to (or as a consequence		ular di	Lseas	e				Death
_	Sequentially list conditions, b.								
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c. C.	of):							
4	events resulting in death) Last Due to (or as a consequence	of):							
	d. Munpended	,27 , perME,	g854,4/	/24/0	6 TT				
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	2 Fet	al death	3	Ectopic pregn	ancy	23d. Date of Month	-	, Day Year
2	1 Yes 2 No 9 Unknown 9 Unknown	eath 5 Oth	ner (S <i>pecify</i>)	i					
2	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying ca	use give	en in Part I.				the cause of death?
3						24a. W	as an 24b	. Were aut	topsy findings available
2						au	itopsy erform <u>ed</u> ?		ompletion of cause of
)	25. Was case referred to medical		26.F	Place of	Death (Check				- 2 140
)	examiner?	ER/Outpatient			or:		Residence 6	Other	
	27. Manner of Death 28a Date of Injury	28b Time of In			t Work?		be how injury occur		
	1 X Natural 5 Pending (Month, Day, Year)	, ,,,,,,	1		2 No	Lou. Descri	So now injury occur	ii eu	

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

Certification: To Be Completed by Physician/Medical Fyaminer Medical

State

Registrar

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c License number

O.C.M.E.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

28f. Location (Street and Number or Rural Route Number, City

or Town, State)

30. Name and address of person who completed cause of death (Item 23a)

Investigation

Could not be

determined

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD

31. Date filed (Month, Day, Year)

Accident

Suicide

Homicide

APR 1 4 2006



28e. Place of Injury - At home, farm, street, factory, office building, etc.

DHMH 17 Rev 1/2001 OCME 10/2003

·			For State Registrar		State of Ma	iryland /		rtment o tificate				Reg.	$Z \cup U$	6	1 8 4 5
	Physici /Medic		1. Decedent's Name (First Anna	t, Middle, Last)	Grace			Powe1	Ĺ		2. Date of		3 ^{ay} 20	XYear O	3. Time of Death 5 A M
1	Examin	_	4a. Facility Name (If not in	stitution, give	street and number)	-		4b. City, To	wn, or Lo	cation of Deat	h		4c. County	of Death	
			Washington	County	Hospital			Hag	erst	own			Wash	ingt	on
	Funeral		5. Social Security Number		IN OFF	(In yrs. last		If Under 1 Months D		Under 24 Hrs lours Min.		Birth Day, Ye			place (State or Foreign
	Director	}	233-34-6040		3 × 2X 8	32	Yrs.				Aug. 2	2, 1	923		Virginia
	and w	}	Usual Residence of Deced	County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	Maryl f ehc	ō	MD Wa	shingto	n l	Час									1 ∰ Yes 2 □ No
	the 1	ect	10e. Street and Number	Burnge	711	nage	ersto	10f. Zip Co	ode			10g.	Citizen of \	What Cou	
	3a or		926 Oak Hi	11 Ave.				2174	. 2				U.S	. Δ .	,
	death	era	11. Marital Status		12. Was Decedent E	ver in U.S.	13. \	Vas Deceden	t of Hispa	nic Origin? (S	pecity Yes or	No-	14. Rac	e - Ameri	can Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heatth and Mental Hygiene. Item 27 is marked other than "natural, or iteme 23a or 28a-f ehow other treumatic event, the Madical Examinar must be notified at	by Funeral Director	1 Never Married 2 3 🛣 Widowed 4 □ D	_	Armed Forces? 1 ☐ Yes 2 ☑ N tf Yes, Give Year or Dates:	lo	1	Yes, specify ☐ Yes 2X		Nexican, Puer Specify:	to Rican, etc.)		Specify	ck, White,	
À	2 hou	ted	15. D	ecedent's Edu	cation	1	6a. Deced	ent's Usual C	ocupatio	n .	4.1	16b	. Kind of B		
215	within 7 iene. then "n	Completed	Elementary/Secondary	y highest grade (0-12)	College (1-4or 5-	+)	life. L	OO NOT use	retired)	ng most of wo	rking				
21	e filed within at Hygiene. I other than "	ا ا	12				Beaut	ician					eauty		
2	be fill tal Hy of oth	Be	17. Father's Name (First, I								me (First, Midd			,	
<u>ya</u>	should Ind Meni	၉	Edwin Guy F						L	ouella	Vivian	Ri	nehar	t	
Ja	2 sho and is m		19a. Informant's Name/Re								ural Route Nun				Code)
6	1 and 2 Health em 27	1	Robert E. P		Son	20h Bloo	926 C	ak Hil	.1 Av	e., Ha	gerstov				0
0	ges 1 If of H If ite or ot		20a. Method of Disposition 1 ★ Burial 2 □ Cren		emoval from State	ceme	etery, cren	sition (Name natory or othe	r place)	1	Date	20c.	Location -	City or I	own, State
Baltimore, Maryland	t. Pa rtmen rtant:		4 Donation 5 0			Rest		n Ceme			/2006		erst		
Bal	permit. Pages: Department of I- Important: If Ite eny injury or ot once.		21. Signature of Funeral S	Service License	<u> </u>						est Hav Ave., H				
			23a. Part1. Enter the dise shock, or heart faitur	ease, or complete. List only or	cations that ceused ne cause on each line	the death. [o not ente	er the mode o	f dying, s	uch as cardia	c or respiratory	arrest,			Approximate Interval Between
1	Physician		tmmediate Cause (Finat disease or condition		58P9	515									Onset and Death
1	/Medical Examiner		resulting in death)		Due to (or as a	a consequen		. 1							
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	ed sit	lue	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ite 👢	Due to (or as a	consequen	ce of):								
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387	ficate phys	edical						-							
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	s that		Part tt. Other significant of							Part I.	23e. Di	d tobacc	o use cont	ribute to t	he cause of death?
rds	w require: been sig should be	Completed by	ALLIE F			-					`		2 🗆 No	3 🗆 Prol	pably 4 Unknown
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Ě	The page	E O	DIABET	25							pe 1□ Yes	rformed;	7 0	death?	
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Ž	hysic his ca I dire	ဥ	1 ☐ Yes 2 ☐ No	F	lospital: Inpatier		Outpatien	3□ DOA	Other:	4 🗌 Nursing H	lome 5□Re	sidence	6 □Oth	er (Speci	(y)
Division of Vital Records,	fing P. After t funera	Certification;		Pending	28a. Date of Injun (Month, Day	Year) 28	b. Time of Injury	28c.	Injury at Work?	2 🗆 No	28d. Describ	e how in	njury occurr	ber	
Si	death death ctor: , the	lcat	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigation Could not be	28e. Place of Inju	ry - At home	farm stre			2 140	28f Location	(Street	and Numb	er or Pur	al Route Number,
≦	after after Dire	erti	4 Homicide	determined	building, etc.	. (Specify)	, 141111, 5111	out, lactory, o	11100		City or 1	own, St	ate)	or or right	ar modite reamber,
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	To th withir To th comp	Me	29b. Signature and title of	Certifier					icense nu		7	29d. l	Date signed	d (Month,	Day, Year)
			▶ UV	1				D	006	232	1	4	7/10	100	0
	5		30. Name and address of 368 M	person who co	mpleted cause of de	eath (Item 23	a) (Type, T D W	Print)	MO	21	140.		7.	4	
	Sta		31. Date filed (Month, Day	r, Year)	32. Registra	r's Signature	1								-
	Registr	ar	APR 1	4 2006	32. Registra	J. A	hoese	Care de la care de la							

Director Section Color	ntes an Indian, etc. ite dustry ectronics/ Code) 921 wn, State
Sara Jane Palmer As Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 5. Social Security Number 5. Social Security Number 6. Sex No. 1	lace (State or Foreign try) ISYlvania Od. Inside City Limits 1 Yes 2 No stry? Ates an Indian, etc. ite dustry ectronics/ Code) 921 wn, State
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20a. Method of Disposition Section Content Conten	wn, State
Physician //Medical Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	
Physician //Medical Examiner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	• •
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Physician /Medical Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Full won 19 Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between
Medical Examiner Due to (or as a consequence of): Hy W Ka (ew/4) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Onset and Death
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
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nesulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
n # 64 =	
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FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 23d. Date of delike Month 25d. No 9 Unknown 25d. Date of delike Month 25d. No 9 Unknown 25d. Date of delike Month 25d. No 9 Unknown 25d. Date of delike Month 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date of delike 25d. Date	Day Year
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	e cause of death?
1 Yes 2 No 3 Pro	ably 4 Hnknown
24a. Was an autopsy performed? 1 Yes 2 No 3 Pro	psy findings available impletion of cause of
1 Yes 2 No 3 Pro 24a. Was an autopsy performed? 1 Yes 2 No 3 Pro 24a. Was an autopsy performed? 1 Yes 2 No 3 Pro 24b. Were autopsy performed? 1 Yes 2 No 3 Pro 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)	2 No
1 Yes 2 No 1 Yes	
Hospital: 1 Ho	0
U	
27. Manner of Death 1 1 2 Natural 2	l Route Number,
The state of the s	
25. Was case referred to medical examiner? 1	
Secretary 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)	lated. the cause(s)
april 7 00055/90 April 7	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	the cause(s)
Alfred Pirro Urion Hospital 106 Bow St Elkton, me 2	Day, Year)
State 31. Date filed (Month, Day, Year) Registrar APR 1 4 2006	Day, Year)

			1 - For State Registrer	State of	of Marylar		artment of I		ind Me	ental H		2 N N I	6	118	167
- 5	(A) , s.	3	Decedent's Name (First, Middle	e, Last)					1 2	2. Date of D				3. Time	of Death
	Physici /Medie		Samantha Renee	Parsons						Month April	_	2006	Year	12:54	P M
	Examir		4a. Facility Name (If not institution		ımber)		4b. City, Town, o	or Location of		PLIL		4c. County o	f Death	F2.57	
- 8			Frederick Memor	ial Hospi	lta1		Frederi	ck			1	reder	ick		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		If Under 1 Year Months Days		24 Hrs. 8	B. Date of B	irth			olece (State	or Foreign
ς.	Director		224-65-9661	10 10 201	3	3 Yrs.						2002			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							IOd. Inside (City Limits
	Mary f ehc	ŏ	Many land England		T7 . 11		4								s 2 No
	28e	Director	Maryland Freder 10e. Street and Number	ICK	Walk	cersvil	10f. Zip Code				10a.	Citizen of WI	hat Cour	ntry?	
	3a or		130 Sandalwood	Court										, .	
	deeth ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	21793 Was Decedent of F	Hispanic Orig	in? (Speci	ity Yes or N	USA 10-		- Americ	an Indian,	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28e-f show other traumatic event, the Medical Experiment must be notified at	by	1 X Never Married 2 Mar 3 Widowed 4 Divorced	If Yes G	2∭ No ive	ľ	f Yes, specify Cub 1 ☐ Yes 2 🔀 No		, Puerto Ri	ican, etc.)		Specify:	, White,		
Ď.	2 ho	ted	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	pation			16b	. Kind of Bus	Whit mess/In		
212	thin 7	Completed	(Specify only nighe Elementary/Secondary (0-12)	st grade completed) College (life.	kind of work done DO NOT use retire	during most d)	of working	7				-	
2	od wit	200	0			N/A_					N/	Ά			
2	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle,	Last)				18. Mother	r's Name (First, Middl	e, Maio	len Sumame)		
<u>ya</u>	should the marked umartice	2	David James Par	sons				Amy M	[iche]	lle Ke	eene	y			
a	2 she and is m		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street	and Number	r or Rural I	Route Num	ber, Cit	y or Town, S	tate, Zip	Code)	
	tealth im 27 her tr		David Parsons,	father		130 S	andalwoo	d Cour							21793
altimore,	Pages 1 nent of H ont: If Ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from		Place of Dispo cemetery, crei	sition (Name of natory or other pla	сө)	Da	te	20c.	Location - C	ity or To	own, State	
E	Pag ment tent:		4 □ Donation 5 □ Other (S		Mt	. Pros	ect Chur	ch Cer	m. 4/	12/20	06	Lewist	own :	Mary	land
Bai	permit. Pages Depertment of Importent: If I eny Injury or o		21. Signature of Funaral Senace	Lieucisce		- 21	. Name and Addre	ec of Facility	Keene	ey and	і Ва	sford	Fun	eral	Home
	40 = 0		Kyan M.	Deign		0999 1	06 East (Church	Stre	eet, E	red	erick,	, MD	2170	
			23a. Part1. Inter the disease, or shock, or heart failure. List	only one cause on	caused the deat each line.	th. Do not ent	er the mode of dyli	ng, such as o	cardiac or i	respiratory	arrest,			Approxima Interval Be	etween
	Physician		Immediate Clase (Final disease or condition	a Cardi	ac Arre	st							- 1	Onset and	Death
	/Medical Examiner		resulting in death)		(or as a conseq										
6		_	Sequentially list conditions,	b. Septo	-Optic D	ysplas	ia with Se	evere	Deve1	opmen	ıta1	Delay	7		
1	ed sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conseq								į		
V	and and II-tran	хап	that initiated events resulting in death) Last		ple Bir		ects								
8760,	cate be executed physicien and the burial-transi														
587	cate phys	G d													
×	law requires that the death certificate be executed as been signed by the ettending physicien and . should be deteched for use as the burial-transit											201			
Box	death e etter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No		oirth 2 Feta		Ectopic pregnancy Other (specify)	У				Mont.		Day	Year
o.	the c y the schec	Jys	9 Unknown	9□ Unkn	own										
2	res that the de signed by the e be deleched f	by Pi	Part II. Other significant condition	ons contributing to d	eath but not res	ulting in the u	nderlying cause giv	ren in Part I.		23e. Did	tobacc	o use contrib	ute to th	ne cause of	death?
Sp	quires n sign									10	Yes	2 X No 3	Prob	abiy 4 🗆]Unknown
Vital Records,	w require s been si should t	Completed								24a. Wa	s an	24b. W	ere auto	psy findings	s available
¥	9 4 6	E,							_	auto	opsy formed	? de	or to cor ath?	npletion of	cause of
ta	ilcian: Th certificate rector, pag	(D)	25. Was case referred to medical			0.00	_	26 Place	of Death #	1 □ Yes Check only		No 1L	Yes	2 ∐ No	
	Physician: rthis certific ral director,	0 0	examiner? 1 ☐ Yes 2 💢 No	Hospital:	Inpatient 2X	ER/Outpatier	t 3 DOA Oth	ac				6 Other	(Specifi	d	
10	g Ph er thi	n: T	27. Manner of Death	28a. Date		28b. Time of	28c. Injur					jury occurred		′/	
<u>o</u>	Attending in death.	ate	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	9	III, Day Fear)	Injury		rk? Yes 2∐N	lo						
DIVISION	l or Attendi efter death. Director: A in by the fu	110	3 ☐ Suicide 6 ☐ Could a determined	ined 286. Place	of Injury At he	ome, farm, str	eet, factory, office		28	f. Location	(Street	and Number	or Rura	l Route Nur	nber,
ā	s efte el Dir	Certification:	- Citionisias	Duild	ing, aic. (Spacin	y /				City or To	own, St	are)			
	To the Hospital or A within 24 hours efter to the Funerel Directomplelely filled in by	edical												ated. the cause(s)
	withir To the Comp	Me	29b. Signature and title of certifie		/	1	29c. Licens	e number			29d. [Date signed (Month,	Dey, Year)	
}			10 1	1/1/) ;	V (\	D2356	1			Anz	:i1 10	20	06	
	7		30. Name and address of person	who completed caus	se of death (Item	n 23a) (Type,		_			WhI	11 10	, 20	00	
	1		Ernesto Torres,				•	Frede	rick.	Marv	1an	d 217	02		
	Sta		31. Date filed (Month, Day, Year)	32. F	legistrar's Signa	ature									
	Registr	ar	APR 1 4 2	2006 Men	in the	free	w								
				7		- /									

Registrar

			For State Registrar	State of Marylar	nd / Depa	artment (Mental Hy	giene	1101.0
9,7	Physici		1. Decedent's Name (First, Middle, La.	HARLES PAR	KER			2. Date of Dea Month		
	/Medic Examin		4a. Facility Name (If not institution, giv. +HE MEMOR 5. Social Security Number 6. S	IAL HOSPI			wn, or Location of Dea	ıth	4c. County of Dea	ath OT
No.	Funeral Director		220-52-0766 Usual Residence of Decedent	∆ M 2□F 5.	5 Yrs.	Months [Days Hours Mir	Feb. 1	7,1951 _{Ma.}	
	the Marytar 28a-f show	Director	MD Dorche 10a. State 10b. County Dorche		ty, Town or Lo		lurlock		10g. Citizen of What C	10d. Inside City Limits 1 Tyes 2 No
	th with 23e or	al Dir	6213 Mill Road			Tor. Zip Or	21643		United St	•
036	. Pages 1 and 2 should be filed within 72 hours after death with the Maryland irnent of Health and Mental Hyglene. It after 27 is marked other than "natural", or Itama 23a or 28e-f show jury or other traumatic event, Ita Medical Exact par marked be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □Yes 2 ☑No If Yes, Give Year or Dates:			t of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)		
21215-0036	within 72 ho ane. than "natur tha Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation ide completed) College (1-4or 5+)	(Give	dent's Usual (kind of work DO NOT use	done during most of w retired)	orking	16b. Kind of Busines:	
Maryland 2	uld be filed Jental Hygid rked other tilc event, I	To Be Co	17. Father's Name (First, Middle, Last, Charles Park			Jabore	18. Mother's Na	or Brum		
Mary	id 2 should he and he trauma		19a. Informant's Name/Relationship (Rosetta Parker	• • • • • • • • • • • • • • • • • • • •			treet and Number or F		or, City or Town, State, MD 2164	
Baltimore,	Pages 1 an nent of Heal nt: If item 2 iry or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specification)	20b. I	Place of Dispo cemetery, crei	sition (Name matory or othe	of or place)	Date	20c. Location - City o	r Town, State
Balti	permit. Pa Depertmen Important: any njury once		21. Signature of Funeral Service Licer		2:	2. Name and	Address of Facility F	ramptom	Funeral ralsburg	Home, PA
A A	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Finer Linderlying	a. Due to (or as a consect b. Due to (or as a consect b.	plend of): 2 ~ 5 & //	11/ /	Abilone abiles			Approximate Interval Between Onset and Death 3 AMPLYS
x 68760,	death certificate be executed attending physician and of for use as the burial-transit	/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	c. LE/O My Due to (or as a consec d		COMA	OF THE	Spani	23d. Date of de	years
.O. Box		Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		Ectopic preg Other (speci			Month	Day Year
ords, P	n requires that the been signed by th should be detache	þ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying caus	se given in Part I.		obacco use contribute o	to the cause of death? Probably 4 Unknown
of Vital Record	The law ete has b page 2 sl	Completed						24a. Was autop perfor	sy prior to death?	utopsy findings available completion of cause of s 2 2 No
f Vit	S S	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA		eath <i>Check only o</i> Home 5 Aesid	nel ence 6 □Other <i>(Sp</i> e	ecify)
Division o	After fune	Certification: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o Injury	f 28c	Injury at Work? 1 Yes 2 No		ow injury occurred	
DİVİ	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	building, etc. (Speci.	(y)			City or Tow		
	n 24 ho he Fune	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at to vestigation, in	the time, date and place my opinion, death occ	ce, and due to the courred at the time, o	cause(s) and manner a date and place, and du	is stated. e to the cause(s)
)	Totl within Totl	Σ	29b. Signature and title of certifier	The	in	29c. L	31466		3/24/6	ith, Day, Year)
			30. Name and address of person who Ludwig J. Eg1s	completed cause of death (lies		•	wood Dr.,	Easton	, MD 2160	01
id.	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signary	ature	(sail)				

			1 - For State Registrar	State of	Marylar		artmen rtificat			and M	1ental H	ygie Reg	200	6	85	
	Physic /Medi		1. Decedent's Name (First, Middle, Las Carolyn Carric	k Power							2. Date of I Month March		^{Day} 2006	Year	3. Time of D 1:05A	
	Examir	ner	4a. Facility Name (If not institution, give Asbury–Solomons H	ealth Ca	re Cer		Solo	mons					4c. County	ert		
	Funeral Director		5. Social Security Number 6. Social Security Number 1 579-74-9686 Usual Residence of Decedent	ox	83	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of E NOV 5	Day 9	22		place (State or l	-oreign
	e Maryland Ba-f show	ctor	10a. State 10b. County Maryland Calvert		10c. Ci	ty, Town or Lo								1	0d. Inside City 1 ☐ Yes 2	
	23a or 2	Funeral Director	10e. Street and Number 11750 Asbury Cir	cle			10f. Zip 20	Code 0688					Citizen of V ited :			
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ira Medical Experient must be notified at	d by Fune	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ⊠No		Was Deced f Yes, spec 1 Yes 2		spanic Orig n, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or f Rican, etc.)	No-		k, White,	ean Indian, etc. white	
21215-0036	s within 72 h piene. r than "natu Ir e Medical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th	ucation de completed) College (1-4	or 5+)	16a. Deced (Give life. I	kind of woi DO NOT us	k done d	urina most	of work	ing		wn hor		dustry	
land	2 should be filed and Mental Hygis is marked other aumatic event, iii	To Be C	17. Father's Name (First, Middle, Last) Raymond Carrick								illips		den Surnam	10)		
Maryland	1 and 2 shou Health and N lem 27 is mai		19a. Informant's Name/Relationship (7 Kathy Pica – daug								al Route Num chanic					
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		20b. I	Place of Dispo cemetery, crer ryland	sition (Nam matory or or Veter	ne of ther place ans	'Apri Ceme	l 5 tery	^{Date} 2006		Location -	-	own, State	
Balti	permit. Pages Department of I Important: If ite any injury or or once.		21. Signature of Funeral Service Licen	see		22	. Name an	d Addres	s of Facility	Rau	sch Fu Port	ner	al Ho	ome MD 2	20676	
0	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a	as a consec	th. Do not ent		of dying							Approximate Interval Betwe Onset and De	
,0928	death certificate be executed e attending physician and nd for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consec	quence of):										
.O. Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ○ No 9 □ Unknown	23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	n 2∏Feta tattime of o	al death 3	Ectopic pro						23d. Dat Moi	e of delive	ory Day Yea	ar
rds, P	sign d be	Ď	Part II. Other significant conditions of	ontributing to deat	h but not res	sulting in the ur	nderlying ca	ause give	n in Part I.				21		ne cause of dea ably 4 ∏Unk	
Vital Records,	The ate h page	Completed										opsy formed	? 5	rior to cor leath?	psy findings avi npletion of cau	ailable se of
of	ding Phys n. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp 28a. Date of I (Month,		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 42KNui	rsing Ho	me 5 ☐ Re 28d. Describe	sidence			<i>'</i>)	
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At h , etc. (Special	ome, farm, str	eet, factory	, office			28f. Location City or T	(Street own, St	and Numb (ale)	er or Rura	l Route Numbe	Γ.
	To the Hospital or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier (Check only one)	/sician: To the be iner: On the basi and manner	s of examina	owledge, death ation and/or inv	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, h occurr	and due to the	e cause e, date	e(s) and ma and place, a	nner as st	ated. the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier	Tando M.	0			License				29d.	Date signed		Day, Year)	
	10		Name and address of program who d	ompleted cause of	of death (Iter	п 23() (Туре,	Pright)	Rd,	TK	2ine	e Fre	der	ick)	1) 3	10678	
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 2		ist ar's Signa		Loss						, -		-	

		1 - For State Registrar	State of	Marylan	-	artmen					eg. No	006	1 (351
Physici	an	1. Decedent's Name (First, Middle,	•							Date of Dea Month	h Day	Year	3. Time o	
/Medic			lia Porter							April April	1	2006	8:15	P M
Examin	er	4a. Facility Name (If not institution,		oer)		7.		Location	of Death			ounty of Deat	th	
		6336 Cedar Lane	-	4 //	to a titlet do d		Lumb:		r 24 Hrs.	7 Data of Birth		loward	holone /Ctata	or Comion
Funeral Director		5. Social Security Number 176 26 5901 Usual Residence of Decedent	3. Sex 7. 1 ☐ M 2 🔀 F	97	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day June 2	Year) 190	Co	thplace (State ountry) 7 York	or roreign
land wo		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside C	ity Limits
Mary -fsh	to	MD Howard	3	Col	Lumbia								1 🗌 Yes	2 ∑ No
r 28a	Funeral Director	10e. Street and Number		, 002	- 02.500	10f. Zip	Code			1	0g. Citize	on of What Co	ountry?	
h witi	0	6336 Cedar Lane	Apt 189			210)44				Unit	ed Sta	ites	
deat	ner	11. Marital Status	12. Was Deced	ent Ever in U	l.S. 13.	Was Deced	dent of Hi	ispanic Oi	rigin? (Spe	cify Yes or No- Rican, etc.)	14	Race - Ame Black, Whit		
or its		1 ☐ Never Married 2 ☐ Marrie		⊠ No		1 ☐ Yes		Specify		, , , , , ,	5	Specify:	0, 0.0.	
urali,	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date									' Wh	ite	
72 h	Completed	15. Decedent's (Specify only highest			16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation during mo:	st of worki	ng	16b. Kind	d of Business	/Industry	
Mithin Mithin	d L	Elementary/Secondary (0-12)	College (1-4	for 5+)		eacher		')			E-S	lucatio		
LIIU X I X I 3-0030 be filed within 72 hours after death with the Maryland hal Hygiene ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner mast be motilised at		17. Father's Name (First, Middle, La	L		1 16	eacrier		18. Moth	er's Name	(First, Middle,			711	
	Be c	Carlton Adelbert	*					Fann	y All	Lee				
should be filed within nd Mental Hygiene. I marked other than mattic event, the Mental Hygiene.	욘	19a. Informant's Name/Relationship			19b. Maili	na Address	(Street		-	I Route Number	City or	Town, State, 2	Zip Code)	
Md2 sold 2 sold 3 sold		Duncan C. Peek/S				-				nbia, MI				
re, Mal yld s 1 and 2 should if Health and Mer liem 27 is mark		20a. Method of Disposition		20b. F	Place of Dispo	osition (Nan	ne of	(a)	0	ate	20c. Loc	ation - City or	Town, State	
		1 ☐ Burial 2 🛣 Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		ate	cemetery, cre CCC				4-3-2	2006	Cato	nsvill	e. MD	
artra prts inju		21. Signature of Funeral Service Li		n M010			-			ry H. Wi				Inc.
		Shem Col	Chis - Wi	tuke						ike Ell				
Physician		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition	omplications that cau nly one cause on each	0 0 1		ter the med	le of dyin						Approxima Interval Be Onset and	ite etween
v requires that the death certificate be executed x equires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (So	r as a consec	quence of):	lca	pre	iN	FRI	sen.	Ł	- 4	l we	eh
.C. DOX OO the death certifical y the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		th 2 ☐ Feta nt at time of c	aldeath 3	⊒Ectopic pr ⊒ Other (sp		'			23	d. Date of de Month	livery Day	Year
ords, F.C. requires that the een signed by th hould be detache	by P	Part II. Other significant condition	s contributing to dea	th but not res	sulting in the t	underlying c	ause giv	en in Part	l.	23e. Did to	bacco us	e contribute to	the cause of	death?
quire n sig	d be	ChroNIC	Kudn	ly	d15-	6130				1 🗆 Y	es 21	No 3∏P	robably 4	JUnknown
	Completed									24a. Was a		24b. Were a	utopsy findings completion of	available
g e e e	E		***************************************							autop: perfor	med? 2 DkNo	death?		Cause of
VICAL Sician: 1 Certifical Irector, p	BeC	25. Was case referred to medical						26. Plac	e of Death	(Check only or				
99	0	examiner? 1 ☐ Yes 2 ☐ X No	Hospital: 1 🗆 In	patient 2	ER/Outpatie	nt 3□ DC	Oth Oth	er: 4□N	lursing Ho	me 5 🙀 Resid	ence 6	☐Other (Spe	icify)	
	on: T	27. Manner of Death ↑★ Natural 5 Pending	28a. Date of (Month)	Injury , Day Year)	28b. Time of Injury		28c. Injun Wor			28d. Describe h	ow injury	occurred		
Attending r death. ector: After by the fune	catl	2 Accident investiga 3 Suicide 6 Could no	ation			М		Yes 2						
	Certification;	4 Homicide determin	and 286 Place C	of Injury - At h g, etc. <i>(Speci</i>	nome, farm, st	treet, factor	y, office			28f. Location (S City or Tow	treet and n, State)	Number or H	urai Houte Nui	ποer,
he Hospital or n 24 hours afte he Funeral Dir	Medical	29a. Certifier 1 ** Certifying (Check only one) 2 ** Medical E	Physician: To the bas xaminer: On the bas and manne	sis of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tin i, in my o	ne, date a pinion, de	and place, a eath occurr	and due to the d ed at the time, d	ause(s) a late and p	and manner a place, and du	s stated. e to the cause	(s)
To the I within 2 To the I complet	Σ	29b. Signature and title of certifier	-1.11	. 🔿				e number					th, Day, Year)	
		> KUCT	gxille	yn			1	151	3 75		Apri	1 3, 2	006	
0/2		30. Name and address of person w	no completed cause	death (Ite	m 23a) (Type	, Print)	, ,		01	EIKK	1/1/	- 1 11	7	1000
. JVF		KOLUPKU/SET	2 8	186	CAY	CK 15.	ron	NI	a	ZIKK	1115	E, NO	0 2	073
Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 03		gistrar's Sign	ature	boards								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) APRIL 2006 6, Physician 2:20P DOROTHY MAY ROBEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES LA PLATA CHARLES COUNTY NURSING & REHAB. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M XXX 86 579-14-2182 DEC.18,1919 NEW YORK Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28e-f show other treumetic event, the Madical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MARYLAND CHARLES LA PLATA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10200 LA PLATA ROAD 20646 U.S.A. Items 23e Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) OWN HOME 12 HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Menfal Health If item 27 Is marked others. PRICE DEHURST WILLIAM MARION 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SANDRA GARDINER-DAUGHTER 14003 EDWARD GARDINER RD., MECHANICSVILLE, MD 20c. Location - City or Town, State 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) M Department of Importent: If eny injury or once. MARYLAND VETERANS CEM. 4-11-06 CHELTENHAM, MD 21. Signature Funeral Service Licenses M-00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final Pnysician 910 week disease or condition resulting in death) /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseq Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. as the IF FEMALE nse (23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes en 2**X** No Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 2 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) his 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural 5 Pending investigation death. 1 Tes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel I 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 5625 Allentown Rd, #101, Camp Springo, MD 20146

30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print)

Fatima Hussein, MD

31. Date filed (Mogth, Day, Year)
APR 1 4 2006

			11000	State of Marylan	nd / Dep	artment	of Health	and Me	ental Hvo	aiene	_09.5.0.		
•		1	For State Registrar	otato of marytar			of Death			Reg. No.	006	1185	3
- 40	***		Decedent's Name (First, Middle, La	st)				1:	2. Date of Dea	ath		3. Time of	Death
-53.	Physicia /Medic		Luverne Serina Ri:	ffle				A	Month Dril 7	Day 20	Year	3:30	P^{M}
1	Examin	ωı <u>.</u>	4a. Facility Name (If not institution, giv			4b. City, T	own, or Location				County of Deati	h	
		ે ત	College View Cent			Frede					rederick		
	Funeral	- 500	5. Social Security Number 6. S	□M 2XTE			Year If Under Days Hours	Min.	B. Date of Birti (Month, Day	v. Year)	9. Birtl Co	hplace (State o. untry)	r Foreign
Tink	Director		261-42-5444 Usuel Residence of Decedent	74					sept. 2	29,	1931 Ala	abama	
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	B Mar	cto	Maryland Frederic	c Ada	mstown							1 🗌 Yes	2 X No
	or 26	Directo	10e. Street and Number			10f. Zip (Code			10g. Citi	izen ol What Co	untry?	
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_	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 2.No	1.3.	If Yes, specif	ent of Hispanic Or fy Cuban, Mexica	in, Puerto R	ican, etc.)		Black, White		
936	urs af	by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No Specity	<i>'</i> :			Specify: Whi	te	
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or items 23a or 28a-f ehow tha Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gro	ducation		dent's Usual	Occupation k done during mos	st of working	a	16b. K	ind of Business/		
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and	ntal H	Be								WILLIOSI	Sumamer		
Maryland	should nd Men marke umatic	٩	Hamilton Richerson 19a. Informant's Name/Relationship (19b. Mail	ing Address	Bess1 (Street and Numb	Le Mor ber or Rural		er, City o	or Town, State, Z	Zip Code)	···
	permit. Pages 1 and 2 should be fited within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than. natural; or items 23a or 28a-f show appring to other traumatic event, he Medical Examiner must be notified at addition.		Clav Riffle, son		1		all Cour			91			21710
Baltimore,	r Head item		20a. Method of Disposition		Place of Disp	osition (Name	e of		ite		ocation - City or		
E	Pages nent of ant: If it		1 ☐ Burial 2 XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemoval from State	•	•	matory	4/9/20	006	Smit	thsburg,	Maryla	and
a	permit. Departn imports any inju		21. Signature of Funeral Service Lice				Address of Facil						
<u></u>	90 E E 9		yau M				t Church				ick, MD		
			23a. Part1. Ear the disease, or comshock, it leart failure. List only	plications that caused the dea one cause on each line.	th. Do not en	iter the mode	of dying, such as	s cardiac or	respiratory ar	rrest,		Approximate Interval Bet Onset and I	ween
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	/Medical Examiner		Tooling it down,	Due to (or as a consec	quence of):								
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x 68	The law requires that the death certifica ste has been signed by the ettending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE;	23c. If yes, outcome of pregn	2001								
Вох	ettend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3	□Ectopic pre					23d. Date of dei Month		rear .
o.	the de	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□ Unknown	Journ 5								
Ω.	s that ned b e deta	by Pł	Part II. Other significant conditions	contributing to death but not re-	sulting in the	underlying ca	use given in Part	ı.	23e. Did to	obacco i	use contribute to	the cause of d	eath?
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m m	The The ete ha	Com	Mellitis	_					perfo	rmed? 2 X No	death? 1 ☐ Yes		
Division of Vital Records,	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Liia-i				ce of Death	(Check only o	one)			
of \	Physi this c	٦.	1 ☐ Yes 2 🔯 No 27. Manner ol Death	Hospital: 1 Inpatient 2	ER/Outpatie				e 5 Resident		6 Other (Spe	cify)	
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	To the Hospital or Attending Physician: The lav within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1X Certifying P	hysician: To the best of my kn miner: On the basis of examin	owledge, dea	th occurred a	at the time, date a	and place, a	nd due to the	cause(s) and manner as	stated.	1
	the Him 24 the Fi	ledical	one)	and manner stated.	ation and or i								
	To To	Σ	29b. Signature and title of certifier				License number				te signed (Mont		
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_	4		30. Name and address of person who	to mo	6 lo	grh	D4716	BRU	NSWK	K, V	mp 21	716	
7	Sta Registi		31. Date filed (Month, Day, Year) APR 1 4 20	Registrar's Sign	nature	while	t						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylar		artment of H rtificate of L			ene . No. 006	11854				
	Dhusisi	8	1. Decedent's Name (First, Middle, I	.ast)				2. Date of Death Month	onth Day Yeer					
	Physici /Medio		Durward Duane	Ragan				March 2	4, 2006	7:05p. M				
1	Examin		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Deat	h	4c. County of Dea					
			Calvert Memoria	l Hospital		Prince F			Calvert	County				
	Funeral		Social Security Number 6	Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bit	thplace (State or Foreign ountry)				
	Director		536-18-0985	1XM 2□F 81	Yrs.			Aug. 11		Oregon				
	ק ע		Usual Residence of Decedent 10a. State 10b. County	10c C	ty, Town or Lo	cation				10d. Inside City Limits				
	anyia sho	-	Tod. State	100.00	ty, TOWIT OF LO	Cation				1 ☐ Yes 2 No				
	8a-f	octc		: County S	underla									
	vith th	급	10e. Street and Number			10f. Zip Code		10g	j. Citizen of What C	ountry?				
	n 72 hours after death with the Marylan "naturel", or iteme 23a or 28a-f show suited Exercities mant be notilised at	Funeral Director	6880 Den-Mar Lar			20689			U.S.A.					
	er de	nne	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi					
9	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🎇 No	Specify:		Specify: W	hite				
3	hour	b F	15. Decedent's	Year or Dates:	16a Donor	dontia I laval Ossva	ntian	10	b Kind of Business					
215-0036	within 72 hours after death with the Maryland ene. Itan "natural", or iteme 23a or 28a-f show Ita Medical Endrilles mast be nutified at	Completed	(Specify only highest s	rade completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of wo	rking	b. Kind of Business	vindustry				
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Maryland	should be nd Mental marked c	To B	Durward B. Raga	Belle Will										
Man	12 sho h and 7 is m traum		19a. Informant's Name/Relationship Maragret A. Raga			_	Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ox 103, Sunderland, Maryland 20689							
	Heell Heell Heell ther		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place								
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n	permit. Page Department of important: If any injury or once.		Machael W.	liee						s, MD 20736				
			23a. Part1. Enter the disease, or co	mplications that caused the dea						Approximate				
	©. Dhuaician		shock, or heart failure. List on Immediate Cause (Final					/2155		Interval Between Onset and Death				
}	Physician /Medical	disease of condition resulting in death) NEAD AND ELBOW /MVRIES Due to (or as a consequence of):												
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ň	death e ette d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		Ectopic pregnancy Other (specify)			Month	Day Year				
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ā	ilcian: Th certificete rector, pag		OF Man ann referred to market					1 Yes 2	No 1 Yes	3 2 □ No				
Vitai		o Be	25. Was case referred to medical examiner?	Hospital:		othe	00	ath Check only one						
ō			1 XYes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	3 DOA	4 Nuising r	lome 5 Residence		ecify)				
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DIVISION	구 등 등 다	Certification;	4 Homicide determine	28e. Place of Injury - At h building, etc. (Speci	(y)	, ractory, office		City or Town, 3	State)	PER 1539				
_	spital ours a nerel (29a, Certifier 1 Certifying	Physician: To the best of my kn			ne date and nisos			SUNDERLY MY				
	\$ 5.55	Medicai	(Check only 2 Medical Ex	aminer: On the basis of examination and manner stated.	ation and/or in	vestigation, in my op	pinion, death occu	irred at the time, date	and place, and du	e to the cause(s)				
	To the h within 24 To the F complete	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Mon	th, Day, Year)				
	F > F 0		okara (•		OCME	<u> </u>	Ma	rch 25, 2	2006				
•			30. Name and address of person wh	o completed cause of death /lto	m 23a) (Tune	Print)								
	2+1		ANA RUB		=54/ (1946,	·	n Street	Baltimo	re, Marvl	and 21201				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrars Sign	ature				,,,					
	Registr	-	MAR	2 9 2006	L	Some Miller								

State of Maryland / Department of Health and Mental Hygiene | | For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month MARCH 24, 2006 Year **Physician** 11:47 P M MARTIN ISRAEL RHBIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY 3218 PAULINE DRIVE CHEVY CHASE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, Y 11/02/1915) Birthplace (State or Foreign Country)
 NEW YORK 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Year) 1**∑**M 2□F 115-09-3626 90 Yrs. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at MARYLAND MONTGOMERY CHEVY CHASE 1 ☐ Yes 2 🕅 No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 3218 PAULINE DRIVE IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Heelih and Mental Hygiene. antif item 27 ie marked other then "naturel; or Item ury or other treumatic event, the Madical Examinary or other treumatic event, the Madical Examina 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: CAUCASIAN ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) PROFESSOR EMERITUS OF BIOCHEMISTRY GEORGETOWN UNIVERSITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GUSSIE BUCHBINDER HYMAN RUBIN ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3401 PAULINE DRIVE; CHEVY CHASE MD 20815 DEBORAH RUBIN - DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: if its eny Injury or of 1 Burial 2 □ Cremation 3 A Removal from State 3/27/2006 FALLS CHURCH, VA 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEMORIAL PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME Myelin 11800 NEW HAMPSHIRE AVE; SILVER SPRING MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 days Congestive heart failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 ☐ Fetal death in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> s been signers should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Alzheimers disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Chronic lymphocytic leukemia has autopsy performed? page this certificate 1 ☐ Yes 2√ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 1 ☐ Yes 2x No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Alter 1X Natural 5 Pending Injury 1 Yes 2 No 2 Accident investigation the Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by 4 Homicide within 24 hours a To the Hospital 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D16495 3/25/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOEL GOOZH M.D. 6410 ROCKLEDGE DRIVE SUITE 401; BETHESDA MD 20817 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 3 1 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March **Physician** Charles Franklin Robey 29,2006 10:50AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5010 Old Franklin Road Indian Head
1 Year | If Under 24 Hrs. | 8 Charles April Day Year) 1923 9. Birthplace (State or Foreign 3. Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 218-12-9572 82 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show ir than "natural", or Items 23a or 28a-f short is Medical Exercion must be notified at 1 Yes 2 No MD Charles Director Indian Head 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5010 Old Franklin Road 20640 <u>USA</u> Completed by Funeral filed within 72 hours after death Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Federal Govt. 8 12 should be fited who and Mental Hygies Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be rmit. Pages 1 and 2 should be partment of Health and Menta portant: If item 27 is marked y injury or other traumatic ev James Franklin Robey Edna Gilroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mattie Robey/Wife P.O. Box 531, Indian Head, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Rest Cemetery 4/3/06 La Plata, MD 22. Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licensee M00945 C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of lying, such as car had or respiratory mesh.

27 Dec. BOX 567 LA PLATA MD 20646

Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell Carcenoma Fea **Physician** grais disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy performed? Yes 2 4 No After this certificate 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 X No 5 Tesidence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and D46419 of person who completed cause of death (Item 23a) (Type, Print) 404 Charles St La Plata, MD Charlene A Letchford, MD gistrar's Signature 31. Date filed (Month State Registrar

06-02440 Sanders, Gary	R	- For State egistrar		of Maryland	d / Depa		f Health a	nd Mental I	Hygiene	Reg. No.	006	1 1 8 5 °	
Physician/ Medical Examine	r		Gary Dale Sanders Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death						Month April 9,	Month Day Year 18:0 April 9, 2006 4c. County of Death Harford			
Funeral Director	2	5. Social Security Number 220-62-3008 Jesual Residence of Decedent	6. Se	x 7.7	Age (In yrs. Ia	est birthday) Yrs			lin.	Birth (MM/DD/Y	Cou	nplace (State or Foreigr ntry) ryland	
and show any nce.	1	10b. County Maryland Harf	ord	i.		Town or Locat				10d. lr 1			
Baltimore, MD 21215-0036 permit. Pages! and 2 should be filed within 72 hours after death with the Maryland permit. Pages! and 2 should be filed within 72 hours after death with the Maryland poperment of Health and Mental Hygiene in page 1. The manual profiler at once. poperment. If the 27 is marked other than "natural", or items 23a or 28a-f show in jury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Eumeral Director	To be completed by Fulleral	10e. Street and Number 2821 Churchy 1 11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div 15. Decedent's Education (Spe Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle Troy Dale S 19a. Informant's Name/Relations Peggy L. Sande 20a. Method of Disposition 1 M Burial 2 Crematio 4 Donation 5 Other S 21. Signature of Funeral Service Howard K. McOma: 23a Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	ille tarried vorced vorced tarried tarried vorced tarried solution tarried tar	PROAD 12. Was Decede Armed Force 1 Yes 17 Yes 17 Yes, Give Year or Dates: nly highest grade of College (1-4) College (1-4) Removal from see V (perDVR) illications that cause ach line.	ent Ever in U.ses? 2 No completed) or 5+) State H. seed the death.	2102 as Decedent of tes, specify Cut Yes 2x nt's Usual Occu working life. Do un Grand of the place) Service Name and Addr Comas I 17 Coke he mode of dy	Hispanic Origin? (Jan, Mexican, Puer No specify: pation (Give kind of NOT use retired) 18. Mother's Na Mary reet and Number of NVILLE Rocemetery, e. Corp. 4- ess of Facility Funeral F	of work done me (First, Middl Magdel: Or Rural Route I L., Chui Date 13-06 Iome, P add, Abord or respiratory	white, etc. wify: Wife Business/Incete Comme ame) SON Town, State, MD ion - City or 1	an Indian, 8lack, hite hite hidustry onstruction Zip Code) 21028 Fown, State Maryland			
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State 31. Date filed (Month, Day, Year) Registrar

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Ĺa		30. Name and address of person who	completed cause of death	(Item 23a Tv						- 0				
V		AMIR A. MIRZA AL	IKHANI MD 10	1 CENT	ENNIAL S	ST. STE B P	.O.BOX 1	89∩ т	[,A PI, A T^A	MD 20646				
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			For State Registrar		State	of Maryla		artment of H		ind Me		iene d. No. 0 6	11859
		1. Decedent's Name (First, Middle, Last) 2. Date of Death										3. Time of Death	
	Physician Nevin King Saylor										March	31, 2006	6:35 A M
	/Medic Examin	- 40	4a. Facility Name (If not			mber)		4b. City, Town, or	r Location of	f Death		4c. County of E	
			Calvert Me	le irone	Hospit	:a1		Prince	Frede	rick		Calver	t County
	Funeral		5. Social Security Numb	er 6. S	өх	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)
	Director		578-28-9099)	X M 2□F	81	Yrs.	months buys			Sept. 2	9, 1924	Maryland
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Ö		ysto	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	·	9☐ Unkr		death 3L						
۵.	requires that the d reen signed by the hould be detached		Part II. Other significan	t conditions c	ontributing to o	leath but not re	sulting in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use contribut	te to the cause of death?
ds,	sign sign d be	d by						, ,			1 □ Ye	s 2 No 3	Probably 4L Unknown
of Vital Record	w requi	ompieted									24a. Was a	Oth Mar	
3e	has has	du					<u> </u>				autops perform	y prior	e autopsy findings available to completion of cause of h?
ā	@ CL	O									1 ☐ Yes 2	10	Yes 2□No
Ζï	iicii cer rect	Be	25. Was case referred texaminer?	o medicai	Hospital:		75000	othe Othe	05		Check only on		
of	Phys rthis ral di	٠ <u>.</u>	1 Yes 2 No		28a. Date		ER/Outpatier 28b. Time of	1 30 DOX	# 🗀 1401			nce 6 Other (Specify)
on	Attending in death.	ertification:		Pending investigation	(Moi	nth, Day Year)	Injury	Work	k? Yes 2 □N			,,	
Division	after death after death Director: /	fica	3 Suicide 6	Could not be		e of Injury - At	home, farm, str	eet, factory, office		28	Bf. Location (St	reet and Number o	r Rural Route Number,
Ö	after Dire	erti	4 Homicide	gotominiod	build	ling, etc. (Spec	cify)	· ·			City or Town	, State)	
	Hospital or Att 24 hours after de Funerel Direct etely filled in by t	alc	29a. Certifier	Certifying Ph	ysician: To th	e best of my kr	nowledge, deat	n occurred at the tim	ne, date and	d place, ar	nd due to the ca	use(s) and manne	r as stated.
	e Hos 124 ho Fun Hetely	edical	(Check only 2 one)	Medical Exam	niner: On the l	pasis of examination of the state of the sta	nation and/or in	vestigation, in my op	pinion, deatl	th occurred	d at the time, da	ate and place, and	due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title	of certified				29c. License	e number		2	d. Date signed (M	onth, Day, Year)
			Kelly	かりか	nd	M	10	DO	060	FYC	5	3/31/0	6
			30. Name and address	of person who	completed cau	se of death (Ite	om 23a) (Type,						
1	0+1		The Collins	3 USH	MD.	100 +	COSPIT	AL RO	AD.	PRII	NCE:	FRERIC	k MD 20678
100	Sta		31. Data filed (Month, D	ay, Year)	32.	Registrar's Sign	nature						
4	Regist	rar	MIN US	2005	Rosenar .	K	Smell 8						

			For State Registrar	State of N	/laryland		artmen rtificate			and M		iene	6	11860	
4	Physici		Decedent's Name (First, Middle, L.		Sara R. Saunders						2. Date of Death Month Day Yo Mar 24, 2006			3. Time of Death 10:10 A M	
	/Medic Examin	-	4a. Facility Name (If not institution, g.						Location o		4c. County of E		of Death	1	
art.	Funeral Director		212-20-7515	Sex 7./	Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan 17,	Year) 1920	9. Birth	place (State or Foreign ntry) Maryland	
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD Ca	lvert	10c. City	, Town or Lo	ocalion	Р	ort Rep	oublic				10d. Inside City Limits 1 ☐ Yes 2 No	
	with the 3s or 28e	I Director	10e. Street and Number 1305 Grays Road		10f. Zip	Code	20676	6	1	-	g. Citizen of Whal Country? U.S.A.				
036	72 hours after death with the Maryland "natural", or iteme 23a or 28e-1 show wifest Experiment by neitified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 Yes 2/4 If Yes, Give Year or Dates	s? ∃No			Las Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes				Blac	14. Race - American Indian, Black, White, etc. Specify: Black		
21215-0036	d within jiene. r then "	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12		or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Cook				ng	16b. Kind of Business/Industry Public Schools				
land;	be file ital Hyg od othe	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name								Middle, Maiden Surname) Rebecca Gross				
Maryland	t 2 sho h and h sm rsum		19a. Informant's Name/Relationship Iszetta E. S- Johnson/Do								Route Number c, MD 2067		State, Zij	o Code)	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other tr. once.												: Location - City or Town, State Cheltenham, MD		
Balt	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lic	Jewell		2:	2. Name an Sew 145				d Prince Fr	ederick, M	ID 206	78	
	Physician and /Medical Examiner he prival-transit	cai Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c.	as a conseque as a conseque as a conseque	ence of):	he	m	oTh	ے رو	a χ			Onset and Death	
O. Box 68	that the death certifica led by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Yes 2 No 9 Unknown 9 Unknown 23d. Date 23										te of deliv	ery Day Year	
Division of Vital Records, P.C	ysicien: The law requires is certificete hes been sign director, page 2 should be	Severe Buladorch Controlling to death but not restricting in the underlying cause given in Part. Severe Buladorch Compheed Vascular Display 24a. Was an autopsy performed? 1 yes 2 tho Hospital: 1 the atient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other										3 Prof	oppy findings available impletion of cause of		
	tending leath. tor: After the fune	Certification:	27. Manner Death t Talural 5 Pending 2 Accident 3 Suicide 6 Could not determine	on be 28e. Place of	Injury - Al hoi etc. (Specify		м		val ⟨? Yes 2□	No	28f. Location (St City or Town	reet and Numb		al Route Number,	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	of examinati	vledge, deat ion and/or in	h occurred vestigation	at the tim, in my of	ne, date an pinion, dea	d place, a	and due to the ca	ause(s) and ma ate and place,	inner as s and due t	stated. o the cause(s)	
)	To th within To th compl	Me	29b. Signature and title of certifier T Mul 30. Name and address of person wh				sie-	I	number) (S	42	7 PRINC	9d. Date signer	d (Month,	Day, Year) A 2006	
	6 Sta	ate	ANWAR MUN 31. Date filed (Month, Day, Year)	32. Regi	i [C	ure	40		101	<i>U</i> .	m	D 2	06	78	
	Regist	200	MAR	2 9 2006	Besse	· K	Ann	ALL S							

DHMH 17 Rev 1/2001

State Registrar

2006

		•	For State Registrar	State	of Marylai		rtment					giene	006	118	62
			Decedent's Name (First, Middle	, Last)							2. Date of De	ath		3. Time o	of Death
	Physicia		Samuel Lawre	nce Soan	ıs						Month March	Day 22.	Year 2006	7:57	рм
	/Medic Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City,	Town, or	Location of	of Death			County of Dea		
	Examili	e i	Montgomery Ho	-		ıse	Roc	kvil	1e			l I	1ontgon	ery	
	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under		If Under		8. Date of Bir	h Voar	9. Bit	thplace (State	or Foreign
	Director		216-64-3701	1 7 □M 2□F	61	Yrs.	Months	Days	Hours	Min.	(Month, Da Feb. 5	, 194		ndia	
	13		Usual Residence of Decedent												
	ylan how		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside C	
	a-ta	ç	Maryland Mont	gomery		Beth	esda								2 ⊠ No
	17 12 18 19 19 19 19 19 19 19 19 19 19 19 19 19	lre	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	ountry?	
	n 72 hours after death with the Maryland "nature!", or frems 23a or 28a-f show afteal Examinar must be notified at	Funeral Directo	10504 Westlake					817					JSA		
	dea	ner	11. Marital Status	12. Was De Amed F	cedent Ever in lorces?	U.S. 13.	Was Deced f Yes, spec	ent of Hi	spanic Ori n, Mexicar	igin? (Spe n, Puerto l	cify Yes or No Rican, etc.)	- 1	4. Race - Am Black, Wh		
٥	afte or tr		1 Never Married 2 Marr	If Yes. G	2X No live		1 ☐ Yes 2	2€ No	Specify:				Specify:Asi	an	
Š	hours after turef, or ite	d by	3 Widowed 4 Divorced	Year or	Dates:	1 10 5						105 105	od of Dunings	/Industry	
9500-61212	72 r	Completed	15. Deceden (Specify only higher	t's Education of grade completed	()	(Give	dent's Usua kind of wor DO NOT us	k done a	turina mos	t of working	ng	100. KI	nd of Business	vindustry	
Z	hen vithir	E D	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		spira			ranie	+		Medica	1	
-	be filed within 72 t tal Hygiene. d other then "nati event, tre Medica		17. Father's Name (First, Middle,			I/G	spria	COLY			(First, Middle	Maiden			
Maryiand	od of the control of	Be	Ezra H. Soans	2201/					Leela	awath	i H. M	aben			
Ž	hould d Me mark matic	ပ	19a. Informant's Name/Relations	hin (Type Print)		19b Mailir	a Address	(Street a	and Numb	er or Rura	l Route Numb	er. City or	Town, State,	Zip Code)	
Σ	d 2 s th an trau		Winston S. Ama		sin									MD 209	06
ė,	1 an Heel em 2		20a. Method of Disposition		20b.	Place of Dispo	sition (Nam	ne of	-1	D	ate	20c. Lo	cation - City o	r Town, State	
Baltimore,	nt of nor of or or or or		1 Burial 2 Cremation		n State Ma	cemetery, crer tropolit			1 P		24,	7.1.01	vandris	, Virg	inia
	it. Pa		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		l'E										
Ra	permit. Pages 1 and 2 should by Department of Heelth and Menta important: if tiem 27 is marked eny injury or other traumatic ev <u>once</u> .		NO Karstio	LICONSOO		F	ranci 00 Un	s J.	Col.	ľins Blvd	Funera l, W, S	il Hor ilve	ne Inc. r Sprir	ng, MD	20901
			23a. Part. Enter the disease, or	complications that	caused the de									Approxima	ate
			shock, or heart failure. List Immediate Cause (Final	only one cause on	each line. tric Ca:									Onset and	
	Pnysician /Medical		disease or condition resulting in death)	a											
	Examiner			Due to	o (or as a conse	equence or):									
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a conse	equence of):									
	ted nsit	를	Cause (Disease or injury	(
	axecu al-tra	Examin	that initiated events resulting in death) Last	c	o (or as a conse	equence of):									
760,	ate be executed hysician and the burial-transit	cal													
687	ficate p phy.														
ŏ	death certifica e attending ph d for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		outcome of preg		70					2	23d. Date of d	efivery	
Ď	death a atte	Cas	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	obinth 2 □ Fe gnant at time of		∃Ectopic pr ∃ Other (sp						Month	Day	Year .
o.	the y the	hys	9 Unknown	9□Unl	rnown						-				
s, P	w requires thet the been signed by th should be detache	by P	Part ff. Other significant conditi	ons contributing to	death but not re	esulting in the u	nderlying c	ause give	en in Part	f.	23e. Did	obacco u	se contribute	to the cause of	death?
ğ	quire n sig uld b										10	Yes 2	XINo 3□F	robably 4]Unknown
Record	s bee	Completed									24a. Was		24b. Were	utopsy finding	s available
æ	The law ate has b page 2 s	E									auto perf	psy ormed? 2⊡xNo	death?	s 2 No	Cause of
		O	25. Was case referred to medical						26. Plac	e of Death	(Check only		1	20110	
>	Physician: r this certifica ral director, p	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DC	Oth-	or:				3 ⊠Other (Sp	ecify) Hos	pice
ō	a Phy er thi	H	27. Manner of Death	/8.4.	te of fnjury onth, Day Year)	28b. Time o	of 2	28c. Injun Worl	y at		28d. Describe	how injur	y occurred		-
<u>o</u>	Attending or death.	atlo	1 □ Natural 5 □ Pendi 2 □ Accident invest	ng (**** igation	sini, bay tour,	injury	М		Yes 2]No					
Division of Vital	or Attending lefter death. Director: After in by the funer	100	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ningd 200. Pla	ce of fnjury - At	home, farm, st	reet, factor	y, office			28f. Location City or To	Street an	d Number or I	Rural Route Nu	mber,
ā	5 € 5 ⊆	Certification:	Tomoso		iding, oto. (opo										
	Hospital 24 hours e Funeral I tely filled		29a. Certifier 1 X Certifyi (Check only 2 Medical	ng Physician: To t Examiner: On the	the best of my k	nowledge, dea	h occurred	at the tin	ne, date a	nd place,	and due to the	cause(s)	and manner	as stated.	(s)
	To the Hospital within 24 hours e To the Funeral I completely filled	edical	one)	and m	anner stated.										
	To the within 2 To the complet	Σ	29b. Signature and title of certific	er _			290	c. Licens D356	e number 535				e signed <i>(Mo:</i> ch 23,	nth, Day, Year) 2006	
)			・一大で	\sim	14			ייייי				1.101	OII 25,	2000	
	6		30 Name and address of person Joseph Kaplan,	who completed c	use of death (ft	em 23a) (Type Caster	Mil1	Road	l, Ro	ckvi	lle, MC	208	55		
	<i>V</i>														
		ate	31. Date fifed (Month, Day, Year		. Begistrar's Sig	nature	Caste								
	Regist	rar	31. Date filed (Month, Day, Year) MAR 2 7 2008 32. Begistrar's Signature												

			For State Registrar	State of	Marylan	•	artment of		and Me	ntal Hy	/giene	n a	1100	50
			Decedent's Name (First, Middle	e, Last)				· Douin	2	. Date of D		U.O	3. Time of D) U Death
×	Physici		Stary	Saun	Par	~ ~				Month 3	Bath Day	ZOO6		М
	/Medio		4a. Facility Name (If not institution				4b. City, Town	, or Location o	of Death	<u> </u>		nty of Death	,,0,,,	
Æ	LAAIIII	iei	Minerita PM	and OM	00	tor	12 11	nk				timor	001	
	Funeral		5. Social Security Number	6/Sex 7.	. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 2		. Date of Bi	rth		place (State or	Foreign
	Director		216-74-6068	1□M 21XF	36	Yrs.	Months Day	rs Hours	Min.	(Month, D	ay, Year)	Cou	ntry)	oronger
	ס	'	Usual Residence of Decedent							2C	3, 1969	Texa	LS.	
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City	Limits
	a-f s	cto	Maryland Cecil	L	Nort	h East							1 X Yes :	2 □ No
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other traumatic event, the Medical Experiment must be notified at	by Funeral Directo	10e. Street and Number 407 Merrey Stre	et:			10f. Zip Code 219				10g. Citizen United			
	ems erm	ner	11. Marital Status	12. Was Deced	ent Ever in U		Was Decedent of If Yes, specify C	f Hispanic Orig	gin? (Speci	y Yes or N	o- 14. F	Race - Americ Black, White,		
9	or It	F	1 Never Married 2 Mar	ned 1 ☐ Yes 2			1 ☐ Yes 2√2 N		, , , , , , , , , , , , , , , , , , , ,	Jan, 010./				
21215-0036	72 hours after dea "naturel", or Items idical Exeminar m	d b	3 Widowed 4 Divorced	Year or Date	es:		- X	o specify.			Spe	cify: Whi	te	
5-	72 h	Completed		nt's Education est grade completed)		(Give	dent's Usual Occ kind of work dor	ne during most	of working		16b. Kind o	f Business/In	dustry	
2	han n	Пp	Elementary/Secondary (0-12)	College (1-4	for 5+)		DO NOT use ret liting	ired)			Food W	h	0	
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unc	s should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	Be						18. Mothe	rs Name (/	-irst, Midale	a, Maiden Sun	name)		
Σ	should ind Mening Menin	မ	Frank D. Saunde						n Conv					
Maryland	2 sh and ls m		19a. Informant's Name/Relations				ng Address (Stre						Code)	
	1 and Health sem 27		Jean and Paul I	lainer/pare			lerrey S	treet,						
0	Pages 1 nent of H int: if ite		20a. Method of Disposition 12 Surial 2 Cremation	3 Removal from St	200	emetery, cre-	sition (Name of natory or other p	olace) Ap	$\operatorname{\mathtt{pril}}^{\mathtt{Dat}}$	ľ,		on - City or To		1
Ë	Pa nen ant:		4 Donation 5 Other (5	Specify)	NOT	Cen	t Metho netery	i	2006				Maryl	and
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item eny injury or othe once.		21. Signature of Pungral Services	Licensee		2:	2. Name and Add							
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製品	Physician and // // // // // // // // // // // // //	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Letter Vanie Letter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										Interval Betw. Onset and De	
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2. 2√No 9 □ Unknown		th 2 Feta nt at time of d	I death 3]Ectopic pregnal] Other (specify)				1	Date of delive	ery Day Ye	ar
Vital Records, F	signed d be der	þ	Part II. Other significant conditi	ons contributing to dea	th but not res	ulting in the u	nderlying cause	given in Part I.			tobacco use c		ne cause of dea	
Sor	v req beer shou	Completed								24- 145		b 18/ 4-		1.14
Re	has ge 2	d L								24a. Was		prior to co death?	psy findings av mpletion of cal	ise of
a	T: The									1 ☐ Yes	281 No	1 ☐ Yes	2 🗆 No	
Ζï	sicial certii recto	Be	25. Was case referred to medica examiner?	11 71 6				Othor		Check only			-	
of	Phys this ral di	٦.	1 Yes 2 No	Inp		ER/Outpatier 28b. Time o	IL SEL DOA	4 🗀 INUI			how injury oc		y)	
O	ding h. After fune	ton	1 Naturat 5 ☐ Pendir	28a. Date of (Month, igation	Day Year)	Injury	V	vork? □Yes 2□N		u. Describe	now injury occ	,uned		
isi	deatl deatl stor: / the	Ca	3 ☐ Suicide 6 ☐ Could	not be	f Injune - At he	omo form of	eet, factory, office			f Location	(Ctract and Alv		al Route Numbe	
Division	or A after Direction by	Certification:	4 ☐ Homicide determ	building	g, etc. (Specif	(y)	eet, ractory, onto	X 0	20.		wn, State)	mber or Hura	a Houte Numbe	31,
_	pital ours a eral filled		29a. Certifier 1X Certifyin	ng Physician: To the h	est of my kas	winden dest	h and and at the	time data and	d =1	d d 4- 4-				
	24 h Fun stely	Medical	(Check only 2 Medicel	ng Physician: To the b Examiner: On the bas and manne	is of examina	ition and/or in	vestigation, in m	y opinion, deat	h occurred	at the time	, date and plac	manner as s e, and due to	the cause(s)	
	o the	Me	29b. Signature and title of certifie				29c. Lice	ense number			29d. Date sig	ned (Month.	Day, Year)	
	F 3 F ŏ		K.60 7	n c		MA	Di	7740	Ä		7/2	1-	2	
	-2		30 Nomber de distriction	ubo seculati tur	of de-th "	- 0261 (**		. / /	/		7/3	0/2	-00°	
	3		30. Name and address of person	AR, DI	22	5 6	REEN :	5 + Bi	Altim	ORF.	mp 2	2/201		
The state of the s	Sta Regist		MAR 3 1 2006		gistrar's Signa	perki								

and / Department of Health and Mental Hygiene

			1- State of Maryland / Depar Registrar Certification	tment of Health and M ificate of Death		ene	1 1 0 0 1
Ī	Dhyoisi		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic	al	ETHEL VIRGINIA SHAF 4a. Facility Name (If not institution, give street and number)	RER 4b. City, Town, or Location of Death	March	26, 2006 4c. County of Dea	
	Examin	er	Homewood at Crumland Farms	Frederick		Frederi	
	Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Oct. 28,	9. Bi 1917 Pe	nthplace (State or Foreign country) nnsylvania
	pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca	ation			10d. Inside City Limits
	Maryla 1 sho	tor	Maryland Frederick Ladiesbur				1√Yes 2□No
	or 28a	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What C	Country?
	ath wil	raiD	12509A Woodsboro Pike	21759	-7. 1/	U.S.	
00	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If tiam 27 is marked other then "natural", or itams 23s or 28s-f show any injury or other treumatic avant. It is Madrial Examiner must be notified a sonce.	by Funerai	1 Never Married 2 Married 1 Yes 2 No	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto □ Yes 2 ∑ No <i>Specify:</i>	Bony Yes or No- Rican, etc.)	Black, Wh	
	2 hour		15 Decedent's Education 16a Decede	nt's Usual Occupation	ing 1	6b. Kind of Busines	
7 13	ithin 7, 18. 18. "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	nd of work done during most of work O NOT use retired)		0.0	
7	iled w Hygier thar th		12 Post 17. Father's Name (First, Middle, Last)	master 18. Mother's Nam	U (e (First, Middle, M	S Governm Baiden Surmame)	ent
<u> </u>	lid be f lental l kad o ic ava	To Be	Lemuel R. Kinzey	Anna Cat			
Mary	nd 2 shou Ith and M 27 Is mar treumat	Η,		Address (Street and Number or Run Woodsboro Pike,			
ē,	of Hea		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposic cemetery, crema	tion (Name of atory or other place)	Date 2	Oc. Location - City of	or Town, State
Dairimo	ment anti-		`4 Donation 5 Other (Specific) Mt. Tabor				e, Maryland
מם	Depart Depart Import any in		21. Signature of Funeral Service Licensee	Name and Address of Facility & BERT E. DAILEY &	SON FUNE	RAL HOMES	, P.A.
			23a, Part , Enter the disease, or complete from that caused the death. Do not enter	EAST MAIN STREE the mode of dying, such as cardiac			Approximate Interval Bet, een
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition				Onset and Feath
	/Medical Examiner				1.9	10	1
		e e	Sequentially list conditions, if any, leading to immediate Due to (or s. consequence of):	ive Amet	NS CA	36	
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Ď,	e exection and urial-tr	Exe	resulting in death) Last Due to (or as a consequence of):				
09/90	icate be executed physician and s the burial-transit	edicai	d				
×	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of d	lølivery
מ	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	in the past 12 meeths?	Ectopic pregnancy Other (specify)		Month	Day Year
r. D	law requires that the as been signed by th 2 should be detache	by Pt	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.			to the cause of death?
cords	w require been signature		Visal gast vertes		1 □ Ye		Probably 4 Dunknown
Ž L		Completed	Rhanatoid Acthritis		24a. Was ar autopsy perform	/ prior t	autopsy findings available o completion of cause of ?
		O	25. Was case referred to predical	26 Place of Dea	1 ☐ Yes 2		es 2 No
_	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: A Nursing H		nce 6 Other (S)	pecify)
lo u	ding Pt h. After th funeral		27. Manner 1 eath 1 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	
ISION	uttend death ctor: / y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree	M 1 ☐ Yes 2 ☐ No	28f. Location (Str	eet and Number or	Rural Route Number,
2	el or A s after al Dire	Certification:	4 Homicide determined building, etc. (Specify)	,	City or Town	, State)	
	To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funera	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one) Certifying Physician: To the best of my knowledge, death (Check only one)	occurred at the time, date and place estigation, in my opinion, death occu	and due to the ca red at the time, da	use(s) and manner ate and place, and d	as stated. lue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mo	onth, Day, Year)
	<u></u>		1 spen / A	/\(\) D16428		5/2	7106
١	U		30. Name and address of person who completed cluse of detur (Non 23a) (1) pe. P Casper E. Cline III, MD 300 West 9th	rint) Street, Frederic	k. MD 21	701	11
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	bereet, Frederic	113 111 21	, 51	
	Registr	rar	MAR 2 9 2006	£			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 30-2006 **Physician** CHAINO /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 11301 Bierman Drive SE Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) Dec 22, 1935 Birthplece (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1₩ M 2□ F 220-30-8779 Yrs 70 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ehow. me 23a or 28a-f ehov MD Allegany Cumberland 1 Ves 2 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 11301 Bierman Drive SE 21502 USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "neturel", or item eny injury or other treumetic event, the Mudical Examinant once. 1 DYes 2 No If Tes, Give Year or Dates: Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) truck industry driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John F. Twigg Genevieve Bishop Twigg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11301 Bierman Dr. SE Cumberland MD 21 19a. Informant's Name/Relationship (Type, Print) MD 21502 wife Sara Twigg 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rocky Gap Veterans Cemetery Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/3/2006 Flintstone MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices ^{22. Name and Address of Facility} Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cancer Lung MOS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of) Hospitei or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate hes t autopsy 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: 1 | Inpatient Other: 4 Nursing Home Certification: To 2 ER/Outpatient 3 DOA 5 ∠Nesidence 6 □Other (Specify) this. filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Lescribe how injury occurred 5 Pending investigation 1 Natural To the Hospitei or Attendin within 24 hours after death.

To the Funerel Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)
APR 1 4 2006

PSICINAC

AKOWSKI, M. D., PITTSBURGH VA MEDICAL CTR PITTSBURGH

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MD040978E

4-04-06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please	ype or Print						-	
			For State	State of Mar	yıan				Mental Hygi	ene 2006	11866
			Registrar			Cei	rtificate of	Death		g(No.U U U	11000
	Physici	an	Decedent's Name (First, Middle, Last						Date of Death Month	Day Yeer	3. Time of Death
	/Medic		Ida M. Thoma						Apri1	5, 2006	7:35P [™]
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town,	or Location of Deatl	h	4c. County of De	
) <u>y</u> .		Southern Maryl				Clinto	on If Under 24 Hrs.	Lo Data of Birth	Prince	Georges
	Funeral		Social Security Number 6. Se 10	ix /.Age (□M 252]F		last birthday) 56 Yrs.	Months Days		(Month, Day,	Year) 9. B	rthplace (State or Foreign Country)
	Director		220-40-5065 Usual Residence of Decedent			56 Yrs.			Feb.24	,1940 Wa	sh.,DC
	ow II		10a. State 10b. County	1	IOc. City	y, Town or Lo	cation				10d. Inside City Limits
	mary	ğ	MD P.G.		Τα	amp 1 o	Hills				1 Yes 2 □ No
+	289	Director	10e. Street and Number		10	тпрте	10f. Zip Code		10	g. Citizen of What C	Country?
3	n /z nours aller geam with the maryland "natural", or itama 23a or 28a-f ehow edical Eveninar must be inclined at		2060 Chadwick	Terrace			2074	Ω		Indiana C	L-L
	The 2	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.	S. 13.		Hispanic Origin? (S oan, Mexican, Puert	pecify Yes or No-	Jnited S 14 Race - Arr	ierican Indian.
0	or its		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ XNo					o Hican, etc.)	Black, Wh	ite, etc.
200	Est. o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specity:		Specify:	lack
2	natural',	Completed	15. Decedent's Edi (Specify only highest grad	ucation		16a. Dece	dent's Usual Occu	pation during most of wor	tking 1	6b. Kind of Busines	
7	within y	ple	Elementary/Secondary (0-12)	College (1-4or 5+)		life.	DO NOT use retire	ed)	King		
7		8	9			Dry C	leaner	's Techr		Privat	e
פַ י	al Hy	Be (17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle, M	laiden Sumame)	
<u>X</u>	markad	o_	Joseph T. Riggs	5				Virgi		llen	
	s 1 and 2 should be tiled f Health and Mental Hyg itam 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (T							City or Town, State,	Zip Code)
2	and ealth m 27 m 27	ļ	Barbara J. Bah,	/sister	DOL D	Temp	le Hil	ick Term	yland 2	20748	
0	ä o _ _ _		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	em <i>etery</i> , crer	natory or other pla	ice)	-Date 2	0c. Location - City o	r Iown, State
ē,	ment ant: ury		4 ☐ Donation 5 ☐ Other (Specify		На			Park 4/		Landove	r, MD.
<u>g</u>	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	1	1) 22	2. Name and Addre	ess of Facility Ho	odges &	Edwards	F.H.
_	ತ್ತ ಕ ನ		Januce E	aucuo	2	39	010 Sil	ver Hil	l Rd., S	Suitland	, MD.20746
			23a. Part. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the one cause on each line	ne death	n. Do not ent	er the mode of dyi	ing, such as cardiad	or respiratory arre	st,	Approximate Interval Between Qheet and Death
F	hysician		Immediate Cause (Final disease or condition	. Uro	150	10515					Threet
100	/Medical Examiner		resulting in death)	Due to (or as a	conseq	uenge of):	-1 ,	5			7.1
卷	Lamine	_	Sequentially list conditions,	b	de	ficie	le du	and	1h		Iwell
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<i>V</i>	and and II-tran	сап	that initiated events resulting in death) Last	c. Due to for as a		vence of):	woll				men
`	e be executed sicien and burial-transit	cal E		000000000000000000000000000000000000000	1 0	_ / /	C.1 1	De O	10		Iwell.
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؛ و ×	eath certificate attending physi	Physician/Medi	IF FEMALE:	23c. If yes, outcome of	oregna	ncv				0015111	
ָם מ	death c	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tir	Feta	Ideath 3	Ectopic pregnand Other (specify)	Э		23d. Date of d Month	Blivery Day Year
o i	the de	yslc	1 Yes 2 No 9 Unknown	9☐ Unknown	110010	balli J	_ Ottler (specify)				
7	v requires that the de been signed by the should be detached	F.	Part II. Other significant conditions co	entributing to death but	not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ecords,	sign d be	d by							1 🗆 Yes	s 2 11 No 3 □ F	Probably 4 Unknown
Ö	w requir been si should	Completed							240 1450 00	24h Wasa	vitano, findiana available
စ္တို		mp							24a. Was an autopsy perform	prior to	autopsy findings available completion of cause of
	icate ha								1 ☐ Yes 2	XINo 1□Y€	es 20XNo
=	Pnysician: The lav r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Ot	han	ath (Check only one		
ö	this aldi	. To	1 Tyes 2 No 27. Manner of Death	1 Inpatient	2 🗆	ER/Outpatier 28b. Time o	" 30 DOX	4 🗆 (4013)11g 1	forne 5 ☐ Resider 28d. Describe hov	nce 6 Other (Sp	ecify)
	Afte	tlon	1X Natural 5 ☐ Pending	(Month, Day	Year)	Injury	Wo	ork? ∃Yes 2 □No	200. 2000 100	w many occurred	
<u>s</u>	deat deat ctor: y the	lica	3 Suicide 6 Could not be		v - At ho	ome farm str			28f. Location (Str	eet and Number or I	Rural Route Number,
DIVISION	at or Attending by after death. i Director: After d in by the funer.	Certification:	4 Homicide determined	building, etc.	(Specif	y)	cot, ractory, office		City or Town,	State)	
	e Hospital of Atten 24 hours after deatl e Funeral Director: letely filled in by the	C	29a. Certifier 1 Certifying Phy	ysician: To the best of	my kno	wledge, deat	h occurred at the t	me, date and place	and due to the car	use(s) and manner:	as stated.
	To the Hospital within 24 hours a Yo the Funeral Completely filled	edical	(Check only 2 Medical Examone)	iner: On the basis of e	xamına	tion and/or in	vestigation, in my	opinion, death occu	irred at the time, da	te and place, and di	ue to the cause(s)
:	To the within To the complete	Me	29b. Signature and title of certifier	~	A 11		29c. Licen	se number		d. Date signed (Mor	. /
	1		1/21	1/	Att	endiz	19)-	-2453	>	04,06.	06
	4		30. Name and address of person who d	completed cause of dea	ath (Iten	23a) (Type.	1				
	1		Dr. Laxmi Berw	·				h Ave	Clinto	n, Md. 2	20735
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar		ture			- G + 111 0 U		.0133
7	Registr	ar	MPR 1 4 2006	Made	1%	Dogs	The state of the s				

			For State Registrar	State of Marylan		artment of F tificate of		Mental Hygie _{Reg.}	2000	18	67
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of	Death
	Physicia		Juan i ta	Jean Turking	ut on				Day Year 2006	8:50	AM
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o	or Location of Deat	1.100	4c. County of Death		
	LAGITIM	۲'	Caroline Nursing He	ome. Inc.		Denton			Caroline		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birthr	lace (State or	r Foreign
	Director		221-24-0889	M 2 LF 73	Yrs.	Months Days	Hours Min.	December 8.	1932 Cour	ry) Lyland	
	D	j	Usual Residence of Decedent					Tecesiae co			
	how		10a. State 10b. County	10c. City	y, Town or Lo	cation			1	I 0d. Inside Cit	
	Ma a	ç	Maryland Caroli	ne De	enton					1 🗌 Yeş	2/E No
	11 th	ire	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cour	ntry?	
	23a (Funeral Director	25242 Smith Land	ing Road		216	29	Uni	ted State	s of An	nerica
	dead dead	ner	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of I	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No-	14. Race - Americ Black, White,		
o	or its	Ē	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		Yes 20 No		o risari, croi,	Specify:	etc.	
3	ours	1 by	3 Widowed 4 Divorced	Year or Dates:					' '	asian	
ה ה	72 h	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced (Give	dent's Usual Occup	pation during most of word)	rking 16t	b. Kind of Business/In	dustry	
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7	y gier t, reter	Ö	12	3	Regis	tered Nu			Nursing		
and	d a the fill	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Mai			
<u> </u>	Men Men arke	ဥ	Rev. Thomas John				, 0	Kathryn Y			
191	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If Health and Mental Hygiene. other traumatic avant, tra Medical Examinar must be notified at		19a. Informant's Name/Relationship (Typ		1			iral Route Number, Ci	•		. 20
≥ 	and ealth m 27		Harry Turkington	brother				Road, Dent			29
ם פ	permit. Pages 1 an Department of Heal Important: If Itam 2 any injury or other anges.		20a. Method of Disposition 1 □ 8urial 2 □ Cremation 3 □ Re	moval from State	emetery, crem	sition (Name of natory or other pla	ca)	Date 200	c. Location - City or To	own, State	
	Pages ment of ant: If it ury or o		4 ☐ Donation 5 ☐ Other (Specify)			meteru		5/2006 Del	rton, Mary	land	
ğ	Departs Departs Import any inj 2008		21. Signature of Funeral Service License	9	27	Name and Addre	ess of Facility eral Home	P. A.			
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			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	e cause on each line.			N			interval bety	ween
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′	/Medical		resulting in death)	Due to (or as a consequence	uence of):	CCIVE	7 0 10 10	017	,	7 - 207	
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ĵ	e exe ien al irial-t		resulting in death) Last	Due to (or as a consequ	uence of):						
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6	ng pt	a	IF FEMALE:								
X O D	th ce rendii r use	an/	23b. Was decedent pregnant	ic. If yes, outcome of pregna 1 Live birth 2 Feta		Ectopic pregnanc	y		23d. Date of delive	•	/aa-
	dea ne att	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown		Other (specify)_	,		Month	Day Y	/ear
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Ś	w requires that the death certific been signed by the attending p should be detached for use as		Part II. Other significant conditions cont	,)	ulting in the u	nderlying cause gr	ven in Part I.	. /	co use contribute to the		
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Ĭ	The I te ha	E						performed	? death?		1029 01
Nia N	an: Lifica tor, p	a	25. Was case referred to medical				26. Place of De	ath (Check only one)	140	20110	
5	ysici s cer direc	.0 B	examiner?	ospital: 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Ot	ner: 4 Nursing h	fome 5 Residence	e 6 ☐Other (Specif	(v)	
ō	g Ph er th eral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju	ry at	28d. Describe how	injury occurred		
0	nding sth. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(WOHII, Day 16al)	Injury		Yes 2 □No				
UIVISION	Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he	ome, farm, str	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Rura	al Route Numi	ber,
בֿ	al or	Sert	4 Homeda	building, etc. (Specifi	y)			City or Yours, C	nato)		
	hours hours nere y fille		29a. Certifier 1 Certifying Physi	ician: To the best of my kno	wledge, deatl	n occurred at the t	me, date and place	e, and due to the caus	e(s) and manner as s	tated.	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 or	Medical	(Check only 2 / Medical Examin one)	er: On the basis of examina and manner stated.	ition and/or in	vestigation, in my	opinion, death occi	urred at the time, date	and place, and due to	o the cause(s))
	withii To th	ž	29b. Signature and title of certifier	00	4	29c. Licen	se number	29d.	Date signed (Month,	Day, Year)	
	- "		James?	sites M	D	D	3/37/	3	-24-06		
			30. Name and address of person who cor	mpleted cause of death (Item	п 23а) (Туре,	Print)					
			James Sides. M.D.	920 Market S 32 Registrar's Signa	treet.	Denton.	Marulano	1 21629			
		te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	of a	- 5				

			1 104		ryland / Dep			•	•	
			1 - For State Registrar			rtificate of			ed No.0 0 6	11868
9	i gr		Decedent's Name (First, Middle	, Last)				2. Date of Deat	th	3. Time of Death
	Physicia /Medic		Louis	Edgar	Trott	., J	r.	March 2	28, 2006 Year	3:20 P M
	Examin	de la companya della companya della companya de la companya della	4a. Facility Name (If not institution				r Location of Deat	h	4c. County of Deat	
4			11376 Southern 5. Social Security Number		ulevard (In yrs. last birthday	Dunki If Under 1 Year	rk If Under 24 Hrs	8. Date of Birth	Calver	hplace (State or Foreign
	Funeral Director		216-70-7627	1XM 2□F 4		Months Days	Hours Min.	Sep. 16	7, 1956 Mar	yland
	P		Usual Residence of Decedent		40- 0h T					
	show	7	10a. State 10b. County		10c. City, Town or L		,			10d. Inside City Limits 1 ☐ Yes 2 🖫 No
	28a-f	Director	MD Calve	rt		Dunki 10f. Zip Code	rĸ	1	0g. Citizen of What Co	
	3a or		11376 Southern	Maryland Bo	ulevard	20754			USA	,
	death	Funerai	11 Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, White	
36	or it	y Fu	1 Never Married 2 Marri	ed 1 ☐ Yes 2 🟋 N If Yes, Give	0	1 ☐ Yes 2 ☒ No		,,	Specify:	
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	ed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent	Year or Dates:	16a Dece	edent's Usual Occup	ation		16b. Kind of Business/	lite
7	nin 72 In "na Medic	Completed	(Specify only highes Elementary/Secondary (0-12)		(Give	e kind of work done DO NOT use retire	during most of wo	rking	TOD. INITIA OF DASHIBSS	moustry
212	d with	Com	Elementary/Secondary (0-12)	4		ancial an	alyst		US Treasur	ry Dept.
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, I					me (First, Middle, I		
Maryland	d Men narke	ဥ	Louis Edga 19a. Informant's Name/Relationsh		Sr.	in - Address /Ctroot	Laura			Sansbury Sip Code) 20754
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic evant, the Madical Examinar must be notified at once.	ı	Laura S. Trott			-			evard, Dunk	
re,	s 1 ar if Hea item other		20a. Method of Disposition		20b. Place of Disp				20c. Location - City or	
E	Pages nent of I ant: ff ite		1 ☐ Burial 2 💢 Cremation 4 ☐ Donation 5 ☐ Other (S _i		1	itan Crem		-30-06	Alexandria	a, VA
Baltimore,	permit. Departnimports Imports any inju		21. Signature of Funeral Service	icensee		2. Name and Addre				
	ZQ E = 3		William	X (Nor					, Owings, N	
	47.7		23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on each line	9.				est,	Approximate Interval Between Onset and Death
3	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	chosis	of the	elive			15 years
	Examiner				consequence of):					·
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	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
,260,	icate be executed physicien and s the burial-transit	calE	resulting in deathly case	Due to (or as a	consequence of):					
				d						
Вох	The law requires that the death certifica ale has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		75-4			23d. Date of del	ivery
B	deati ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
P.O.	that the de led by the a detached t	Phy	9 Unknown]				00- Didu-		
ds,	ires that signed I be de	by	Part II. Other significant condition	ns contributing to death bu	t not resulting in the t	anderlying cause giv	en in Paπ I.		pacco use contribute to es 2 → No 3 → Pr	obably 4 Unknown
Vital Records,	w require been si should I	Completed						24a. Wasa	_	itopsy findings available
Re	The law ale has page 2 :	dmo						autops	y prior to death?	completion of cause of
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ath (Check only on		2 □ No
	w 17	To B	examiner? 1 ☐ Yes 2 🂢 No	Hospital: 1 Inpatien	nt 2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	lome 5X Reside	ence 6 Other (Spe	cify)
Division of	ding Phy h. After thi funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (of 28c. Injur Wor	y at k?		ow injury occurred	
isio	or Attendated death Director:	icat	2 Accident investig	ot be 200 Blace of Injur	ry - At home, farm, st		Yes 2 □ No	28f Location (St	reet and Number or Ru	ural Route Number
<u>≤</u> .	alter i Dire	Certification:	4 Homicide determine	building, etc.		, addity, dilied		City or Town		
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1X Certifyin.	g Physician: To the best of	f my knowledge, dea	th occurred at the til	me, date and place	, and due to the ca	ause(s) and manner as	stated.
	To the H within 24 To the Fi complete	ledical	one)	xaminar: On the basis of and manner stat	ed.					
	S on S	Σ	29b. Signature and title of certifier	Juan,	mn	29c. Licens			9d. Date signed (Mont. March 30, 2	
,	,		20 Name and address of parson				17313	T.	MICH 30, 2	
	0		30. Name and address of person of Joyce Owens, M			,	Suite 20	3, Dunkir	ck, MD 2075	54
	Sta		31. Date filed (Month, Day, Year)	32. Registra	s Signature			,		
34	Registr	ar	MAR	3 0 2005	Eseras H.	Come	· · · · · · · · · · · · · · · · · · ·			

			1 - State Registrar	State of Maryland /		rtment of H			giene Reg. No.	6	11869
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physicia /Medic		Jacqueline Scott	Tollett				March	25, 200	Year)6	7:20 A M
	Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death	
			5225 Pooks Hill Rd			Bethes			Montgo		
ı	Funeral		5. Social Security Number 6. Sex 445−34−7295	M 2 F 7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Соц	place (State or Foreign intry)
	Director		Usual Residence of Decedent	12				2-26-1	934	OKT	ihoma
	yland yland		10a. State 10b. County	10c. City, To	wn or Loc	cation					10d. Inside City Limits
	B Mar	ctor	MD Montgome	ry Bet	hesc	la					XXYes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	intry?
	s 23a	ral	5225 Pooks Hill Rd		1	20814			J.S.A.		
' O	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. strang 23a or 28a-f show titam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event. It would be a until the most factor of the fired at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 		Vas Decedent of His Yes, specify Cubar		pecify Yes or No Rican, etc.)		ck, White,	can Indian, , etc.
21215-0036	ral', o	d by	3 ☐ Widowed 4 🏝 Divorced	If Yes, Give Year or Dates:	1	Yes 24 No	Specify:		Specif	Bla	ck
5 0	72 h	etec	15. Decedent's Educ (Specify only highest grade		(Give I	ent's Usual Occupa kind of work done d	uring most of wor	king	16b. Kind of B	usiness/Ir	ndustry
121	within ene. than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D Attor	00 NOT use retired) *n e V			Law		
	filed v Hygie other 1	e Co	17. Father's Name (First, Middle, Last)	31 1	10001	110)	18. Mother's Nan	ne (First, Middle,	Maiden Suman	ne)	
Maryland	2 should be and Mental Is marked or raumatic ave	To Be	George Scott, Sr.					th Bre		ŕ	
lary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (Typ			g Address (Street a				State, Zij	p Code)
	is 1 and 2 of Health ar itam 27 Is other trace		Nicola T. Jefferson 20a, Method of Disposition			Im Avenue	, Swartn	more, PA	20c. Location -	City or T	own State
Baltimore,	Page ent o nt: If		1 ☐ Burial 2 🛣 Cremation 3 🛣 Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State cemet	өгу, сгөп	aatory`or other place Cemetery	" 4-3-	06	Falls Ch	•	
alti	Departm Departm Importer any inju		21. Signature of Funeral Service License								Direction
<u> </u>	88 = 8		Donald (L	tottlenger	10	91 Rockv	ille Pik	e Rockv:	ille, MI		
ı			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	eations that caused the death. Do	not ente	er the mode of dying	, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Metastatic Lun	ıg Ca	rcinoma					Onset and Death 14 Mos.
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):						
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	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
30,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequence	e of):						
8760,	physic the b	dical	d.								
9 x	certific	/Me	IF FEMALE: 23b. Was decedent pregnant 23	lc. If yes, outcome of pregnancy					23d Da	te of deliv	env
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 □ Yes 2 ☒ No	1☐Live birth 2☐Fetal deat 4☐Pregnant at time of death		Ectopic pregnancy Other (specify)			1	nth	Day Year
O.	t the by the tacher	hys	9 Unknown	9Ll Unknown	_						
s, P	res tha signed be de	by P	Part II. Other significant conditions conf	tributing to death but not resulting	in the un	derlying cause give	n in Part I.				he cause of death?
ord	w requir been si should	ted						101	res 2∐No	3 € Proi	bably 4 Unknown
Record	e law has b	Completed						24a. Was autop	sv	prior to co	opsy findings available empletion of cause of
E	Th ate pag							1 ☐ Yes		death?	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Dea				
o		1: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Injury 28b.	outpatient Time of	28c. Injury	r: 4 ☐ Nursing H		lence 6 ∐Oth now injury occur		fy)
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Division	or Attanding after death. Diractor: After in by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, in building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (5 City or Tox		er or Run	al Route Number,
Ö	tal or rs afte al Dira ed in b	Certification:	4 - Homede	Building, etc. (Specify)			in the		m, state)		
	To tha Hospital or within 24 hours afte To tha Funaral Dii completely filled in	Medical		ician: To the best of my knowledger: On the basis of examination a and manner stated.							
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier			29c. License			29d. Date signe	d (Month,	Day, Year)
}			1 Nector Prince	lm		D23308	3		3-27-06		
	10		30. Name and address of person who cor Victor M. Priego,	npleted cause of death (Item 23a) M.D. 6420 Rock1) (Type, F	Print) Dr. Ste	4100 Be	thesda,	MD 2081	7	
	Sta		31. Date filed (Month, Day, Year)	32 Hegistrar's Signature							
	Registr	ar	MAR 3 1 20	UU PROPERT AND	SASTA.						

			For State Registrar		Marylar	nd / Depa			lealth a Death			Reg. N	nn	6	E. de de la constant	370
	Physic	ian	Decedent's Name (First, Middle, L C = 1 = - 5 =	.ast)							2. Date of D Month	D		Year		of Death
	/Medi		Sylvia 4a. Facility Name (If not institution, g	ive street and num		TANNEN	4h City	Tours	Location of		March		2006 c. Co <i>u</i> nty o	f Do oth	7:5	5 A [™]
	Exami	ner	Hebrew Home of G			ton		ckv1		JI Death		"				
	Funeral		5. Social Security Number 6.	Sex 7		. last birthday)	If Unde	r 1 Year	If Under		8. Date of B	irth		t gon	lace (State	e or Foreign
	Director		063-12-1816	1 □ M 2 🛣 F	95	Yrs.	Months	Days	Hours	Min.	May 15	, 10g	910	Bre	86k1y	n, NY
	and	7	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation							1	Od Insido	City Limits
	Maryli f sho	ō		rfax		ak Hill								'		es 2 No
	28a-	rect	10e. Street and Number				10f. Zip	Code				10g. C	itizen of W	hat Cour		
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	ems (ner	11. Marital Status	12. Was Deced	dent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Orig	gin? (Spe	ecify Yes or N Rican, etc.)	lo-			an Indian,	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2	2 ⊠ No		1 Yes		Specify:	i, i dono	riicari, etc.)		Specify:	, White,		
Ö	hour tural'	pa pa	3 Widowed 4 Divorced 15. Decedent's	Year or Da	les:				Al-			1.0				
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212	d with giene	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	Secre							Ва	nkin	ıg	
2	al Hyg	Bec	17. Father's Name (First, Middle, Las	st)					18. Mothe		(First, Middle		n Sumame)		
<u>ya</u>	Ment Ment arked arked	2	Samuel Yaeger								se Rei					
Mar	12 sh and reum		19a. Informant's Name/Relationship								I Route Numi				Code)	
e, 1	1 and Health em 2 ther t		Roberta Gould / 20a. Method of Disposition	daughter							ak Hil.		A ZUI		01-1-	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at ance.		1 Burial 2 Cremation 3	Removal from S	tate Et err	Place of Dispo cemetery, crer nal Lic	natory or o	em . (rdn'.	Apr	11 3.	2006	Bovn	ton.	wn, State Beacl	h. FL
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Box	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna		Ectopic pr					İ	23d. Date	of delive	гу	
	ed for	sicia	in the past 12 months?		nt at time of d		Other (sp						Mont	h	Day	Year
P.0	at the de d by the etached	Phy	9 Unknown													
	ires thai signed t	þ	Part II. Other significant conditions	contributing to dea	th but not res	ulting in the ur	ndertying c	ause give	n in Part I.				use contrib			
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₹	Physicien: This certifical	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	netical 2	ER/Outpatien	2 2 20	Othe	r /	-	(Check only					
0		-	27. Manner of Death	28a. Date of (Month,		28b. Time of		8c. Injury Work		sing Hon	ne 5 ☐ Resi !8d. Describe		6 ☐Other			
<u>ö</u>	Attending r death. sctor: After by the fune	atlo	1 □ Natural 5 □ Pending 2 □ Accident investigation		Day Year)	Injury	м		? es 2∐N	10						
Division	I or Attendated after death Director:	ertification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	286. Place o	f Injury - At he	ome, farm, stre	et, factory	, office		2	28f. Location (City or To			o <i>r Rural</i>	Route Nu	mber,
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	To the Hospital or Attenwithin 24 hours after deatly To the Funerel Director: completely filled in by the	edical	29a. Certifier Certifying P (Check only one) 2 Medical Exa	hysicien: To the b miner: On the bas	is of examina	wledge, death ition and/or inv	occurred restigation,	at the time in my op	e, date and inion, death	l place, a	and due to the	cause(s date an	s) and mann d place, an	er as sta	ated. the cause	(s)
	thin 2	Med	29b. Signature and title of certifier	and manne	r stated.			. License					ate signed (
	/		Anno G	man	m					-4						
	5		30. Name and address of person who	completed cause	of death (Item	n 23a) (Tyne 1	Print)	001	0 - 0	/		rut	Rat	04,	207	16
			DINESH Pa	tel, m	-12-6	121	Mi	M	808	Re	e L	27/	ulli	M	1) 28	852
	Sta		31. Date filed (Month, Day, Year)	9 .	jistrar's Signa	iture A	eall)			/	7	J- 02	/	7		
	Registr	ar	SERT Q 1	anna L	2.10 A	U. All	-									

SYLVIA TANNEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Month **Physician** March 23, Temchin 2:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year **Funeral** Days Hours 1 M 2 √F Months January 19, 1912 069-42-8442 94 Poland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County i Hygiene. other than "natural", or itams 23a or 28a-f ehow vant, the Medical Examinar must be nutified at 1√PYes 2 No Directo "NONE" DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 511 10th Street NE 20003 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify. <u>ک</u> 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be "Unknown" Emil Sommerstein 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 511 10th Street SE Washington DC 20003 Shelley Temchin (Daughter) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 X Removal from State March 26, 2006 V 4 ☐ Donation 5 ☐ Other (Specify) National Crematorium Falls Church VA 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel 21. Signature of Funeral Service Licensee 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 141 JOP2 Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 NO 1 ☐ Yes r death. octor: After this certifica by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Mursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 N 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury s after de. rei Director: Ahr 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funerel (29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 3 Name and address of pe death (Item 23a) (Type, Print) TON 6121

State

Registrar

31. Date filed (Month, Day, Wear)

₩egistrar's Signature

2006

			1 = For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of I			ene g. No. () ()	c 1107/
Ī	Physici		Decedent's Name (First, Middle, Last) ROSE TAUB					2. Date of Death Month MARCH	Day	Year 11:15PM
	/Medio Examir		4a. Facility Name (If not institution, give s	street and number,)	4b. City, Town, o	or Location of Dea		4c. County	
	LAGIIII		Layhill Genesis N	ursing He	ome	Silv	er Sprin	g	Mont	gomery
	Funeral Director		5. Social Security Number 6. Sex 577 600 040	7. A	ge (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		^{Year)} 1912	9. Birthplace (State or Foreign Country) New York
	P .		Usual Residence of Decedent		10+ Cit. T					
	Marylar III ehov	tor	10a. State 10b. County Maryland Montgome	ery	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2基 No
	r 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	Vhat Country?
	h wit		3330 North Leisure	World B	lvd #812	20	906		US	A
36	within 72 hours after deeth with the Maryland iene. rithen "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3234 Vidowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 If Yes, Give Year or Dates:	? Mio	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 202 No	an, Mexican, Pue	Specify Yes or No- to Rican, etc.)	Blac	e - American Indian, k, White, etc. : White
21215-0036	n 72 hou "natura edical E	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	during most of wo		6b. Kind of Bu	siness/Industry
12	within ene.	m du	Elementary/Secondary (0-12)	College (1-4or	5+)	utive Se			II.S. G	overnment
d 2	ĕ \$ ₹ ₹		17. Father's Name (First, Middle, Last)					me (First, Middle, M		
Maryland	d be ental ked c	To Be	Poniomin Director				Dama	TT1		
2	shound M	-	Benjamin Birnbaum 19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Maili	ng Address (Street	Dora and Number or R	urai Route Number,	City or Town,	State, Zip Code)
	es 1 and 2 should be fi of Heelth and Mental H f Itam 27 is marked ot ir other traumatic ever		Roberta Oler / Da	ughter	1522	2 Center	pate Driv	ve Silver	Spring	-MD 20905
Baltimore,	s 1 a of Hee		20a. Method of Disposition		20b. Place of Dispo					City or Town, State
Ę	Pages nt: It	1	1 XBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		emorial		26/2006	Olney,	Maryland
att	permit. Pages 1 Department of H Important: If Its any Injury or ot		21. Signature of Funeral Service Libense	99	/ 2	2. Name and Addre	ess of Facility H1 1	nes Rinald	li Fune	ral Home
m	Depa Impo any I		Town KI	Lew	Ou 1	1800 New	Hampshi	re Ave Sil	lver Sp	ring,MD 20904
8760,	Physician /Medical Examiner but and putal-transit the putal-trans	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	c Obstructi s a consequence of): s a consequence of): s a consequence of):	ve Pulmon	nary Disc	ease		Onset and Death
O. Box 6	iaw requires thet the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnanc	у		23d. Date Mor	e of delivery hth Day Year
<u>α</u>	ires thet signed b d be deta	<u>م</u>	Part II. Other significant conditions con Dementia, Lower 1				ven in Part I.			ibute to the cause of death? 3 Probably 4 Unknown
Ö	w requir been si should	ete			·					
of Vital Records,	The ate h page	Completed	Arthritis Degener	rative ly	уре			24a. Was an autopsy perform	ed? d	Vere autopsy findings available trior to completion of cause of leath? ☐ Yes 2☐ No
'ita	ictan: ' certifica rector, p	Be (25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)	
Ž	disp.	P	1 ☐ Yes 3 No		ient 2 ER/Outpatie	IL 3LI DOA		Home 5 Resider	nce 6 Othe	ar (Specify)
	ding Pt h. After th funeral	ü	27. Manner of Death 1 □ Pending	28a. Date of Injui	ury 28b. Time o ay Year) Injury	Wo		28d. Describe how	w injury occurre	ed
Division	or Atten after deat Director: in by the	Certification	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		njury - At home, farm, st tc. (Specify)]Yes 2 □No	28f. Location (Streetly or Town,		er or Rural Route Number,
	To the Hospital (within 24 hours all To the Funeral Completely filled in	edical (29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best ner: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	h occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the cal urred at the time, da	use(s) and mai te and place, a	nner as stated. and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed	(Month, Day, Year)
	. 2.0		Myna	C/	200	D344	472	N	larch 2	4, 2006
•	1-		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type	Print)	-			., 2000
	6		Lynne Diggs, M.I	10400	Connectic	ut Avenue	#206 Ke	ensington,	Mary1	and 20895
	Sta		31. Date filed (Month, Day, Year) MAR 2 7 2	32. Regist	trar's Signature	oseli)				

		1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of H			iene eg: No	6	1873
13		1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	th Day	Year	3. Time of Death
Phys	ician dical	Clarence	Will	iam	Viar,	Jr.	March			11:00 P M
	niner	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	r Location of Deat	h	4c. County	of Death	
		738 Bay Front	Avenue		Nort	h Beach		An	ne Arı	undel
Funer	al	5. Social Security Number 6	4VIM 2□E	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthplai Country	ce (State or Foreign
Directo	or	223-68-5057	IAJM ZUF	57 Yrs.			July 4		Virgi	nia
pue *		Usuaf Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				100	d. Inside City Limits
/anyla	5	, i	Arundel			h Beach				1 ☐ Yes 2 ☑ No
the A	Director	MD Anne I	arunder		10f. Zip Code	II beacii		0g. Citizen of \	What Country	v?
with page	ā					4				
leath	Funeral	738 Bay Front	12, Was Decedent B	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba		Specify Yes or No-	USA 14. Rac	e - American	ı Indian,
fler of	摳	1 Never Married 2 Marrie	Armed Forces? d 1 X Yes 2 □ N	lo			to Rican, etc.)	Blac	ck, White, etc	2.
urs a	þ	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates: 1		1 ☐ Yes 2 X No	Specify:		Specify	whit	:e
If Z 12.15-0050 filed within 72 hours after death with the Maryland Hybjens, the than "natural", or Items 23s or 28s-f show ont, the Modical Examinar must be notified at	Completed	15. Decedent's (Specify only highest	Education		dent's Usual Occupa		rking	16b. Kind of B	usiness/Indu	stry
thin 7	l ple	Elementary/Secondary (0-12)	College (1-4or 5	lite.	DO NOT use retired	d)	, King			
A will	S	10		Gunn	ery Sgt.,			U.S. M		<u>cy</u>
be file d oth	Be	17. Father's Name (First, Middle, La	ast)			18. Mother's Na	me (First, Middle, i		•	
Men Men	ု	Clarence Wi	lliam Viaı	r, Sr.		Peggy			radlir	
and and temperature		19a. Informant's Name/Relationshi			ing Address (Street					
1 and 1 Health Health other tr		Courtney W. Via	ar, daughtei		15th St.,				11215	
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	Removal from State	cemetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location -	City or Town	1, State
Pag ment ant: ury c		4 Donation 5 Other (Spe		Metropol	itan Crem	atory 4-	-01-06	Alexan	dria,	VA
amili.	9	21. Signature of Fund of Service Li		2	2. Name and Addres	ss of Facility				
4058	a	- William	1 Olar		kausch Fu	neral Ho	me, P.A.	, Owing	s, MD	20736
		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused nly one cause on each lin	the death. Do not en	ter the mode of dyin	ig, such as cardia	c or respiratory arr	est,	lr lr	Approximate nterval Between
Physicia	m	Immediate Cause (Final disease or condition	Hopas	balle	las Ca	arcil	wha			Onset and Death
/Medica		resulting in death)	Due to (or as	a consequence of):	0	faile				
Examine	er	Sequentially list conditions	6. Hent	e Re	ual f	ailer	ve_			
D #	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury	Due to (or as a	a consequence of):		}				
acute ind trans	Examiner	that initiated events	. Repa	hitis C						
be exe	Ä	resulting in death) Last	Due to (pr as	a consequence of):						
ate la la la la la la la la la la la la la	Ical	M	d							
wrequires that the death certifics been signed by the ettending phe should be detached for use as to	Med	IF FEMALE:							1	
ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome	2 Fetal death 3	□Ectopic pregnancy	,			te of delivery onth D	ay Year
e de	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5	Other (specify)					_,
d by letach	Ę		a contribution to dooth bu	st not societies in the	and at time and an area	on in Dard I	220 Didto	bassa usa sant	ributo lo tho	cause of death?
res the signer bed	Ď	Part ff. Other significant condition	s contributing to death bu	It not resulting in the t	indenying cause give	en in Part I.	1 🗆 Ye	1	3 ☐ Probab	
w requires the been signed should be	ted			***************************************				03	J T TODAL	
law las b	Completed						24a. Was a autops	Sy	prior to comp	y findings available pletion of cause of
The The	Co						1 Yes		death? 1 🗌 Yes 2	□No
cien: ertific actor,	Be	25. Was case referred to medical examiner?					ath (Check only or	ne)		
Physic this c	2	1 ☐ Yes 2 💢 No	Hospital: 1 Inpatie			4 Nursing i	lome 5 Reside			
nding P uth. r: Atter t	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	Worl		28d. Describe h	ow infury occur	red	
ttendi death. ctor: A	rtification:	2 Accident investigated a Suicide 6 Could no	t he			Yes 2 □ No				
or Att	E	4 Homicide determin		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28f. Location (Si City or Town		per or Rural F	Route Number,
To the Hospitel or Attending Physicien: The law within 24 burus atter death. To the Funeral Director: Attenthis certificate has completely tilled in by the tuneral director, page 2	Ce	7-6								
Hosp 4 hos Fune ely ti	Medical	(Check only 2 Medical E.	Physician: To the best of raminer: On the basis of	examination and/or is	th occurred at the tin rvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the c urred at the time, d	ause(s) and ma late and place,	anner as stat and due to th	ed. ne cause(s)
the hin 2 the	Med	29b. Signature and title of certifier	and manner sta	ted.	29c. Licens	e number		9d. Date signe	d (Month Dr	v Vaarl
Vilt of O		1) / A (16	han						
		Jums	MONDY	WID	200	6047	2	March	31, 20	JU0
10		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Type	Print)	ומת מיו	NICE DO	ENIM	mi	100624
10		31. Date filed (Month, Day, Year)	OI III)	eath (Item 23a) (Type OO HOSP s Signature	ITTUKUF	TUITKI	NUC TK	LUM	C1111) autoti
	State istrar	MAR	3 1 2005 ► A	Sugrature H	harles					
, icg	- TIGH	MMIX	O T LOOP	address he						

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	1		1 = For Stata Registrar	State of Ma	ryland	-	irtment of				giene Rag. No.	006	1187	
	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of Dea		Year	3. Time of De	eath
)	/Medic Examir	cal	Yvonne P. Whe	e street and number)	al		4b. City, Town,	sert	anc	teril		2006 County of Death	2019:37	<u> </u>
	Funeral Director			Sex 7. Age	68	t birthday) Yrs.	Months Days		Min.	Date of Birti (Month, Day 1/07	v. Year)	Coui	place (State or F ntry) V	oreign
	yland		10a. State 10b. County		10c. City, 7	Town or Lo	cation					1	I Od. Inside City I	Limits
	he Ma 28a-f s	Director	WV Miner	al	Keys	er	T						1 □ Yes 🕺	□ No
	h with t	E D	P.O. Box 604				10f. Zip Code 26	726			-	zen of What Coul	ntry?	
920	within 72 hours after death with the Maryland ane. than "natural", or Iteme 23e or 28e-f show he Maulcel Exeminer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes \$77. If Yes, Give Year or Dates:		11	Vas Decedent of Yes, specify Cul	an, Mexicar	n, Puerto Ri	fy Yes or No- can, etc.)	1	14. Race - Americ Black, White, Specify: Whi	etc.	
Maryland 21215-0036	1 within 72 hours Jiene. r then "neturel", The Madical Exp	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0·12) 1 2			(Give life. L	ent's Usual Occu kind of work done OO NOT use retire	pation during mos	t of working	•		nd of Business/In		
d 2	Hed tygi t, L	a)	17. Father's Name (First, Middle, Last)		HOIII	emaker	18. Mothe	er's Name (First, Middle,		Own hom Surname)	e	
ylar	2 should be fi and Mental h ie marked ot sumatic ever	To B	Leslie C. Lil					1		B. La				
	nd 2 sh lith and 27 le rr r traum		19a. Informant's Name/Relationship (Dyer Whetzel/				.O. Bo					Town, State, Zip	Code)	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any Injury or other traumatic e once.		20a. Method of Disposition 1 Rurial 2 Cremation 3 4 Donation 5 Other (Special		cem	e of Dispos etery, crem	sition (Name of patory or other pla	ice)	Dat 4/12	9	20c. Loc	cation - City or To		_
Balti	permit. Departmit imports any Inju		21. Signature of Funeral Service Lice	da -	`	22. M	Name and Addr	ess of Facilit	era1	Home	. Tn	C -		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	one cause on each lin	e. Stic consequen	Ovar	ian Car		cardiac or 1	espiratory and	rest,		Approximate Interval Betwee Onset and Dea 2 – 3 y	
.O. Box 68760,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a d. d. 23c. If yes, outcome of 1 Dive birth 4 Pregnant at 19 Unknown	of pregnancy	/ ath 3□	Ectopic pregnanc Other (specify)	у			23	3d. Date of delive	ery Day Yea	ır
<u>α</u>	quires that the signed by ald be detact	by	Part II. Other significant conditions of Pulmonary Emb		t not resultin	ng in the un	derlying cause gr	ven in Part I.		23e. Did to	1	se contribute to the	ne cause of deat	
Division of Vital Records,	 The law requires that cate has been signed b page 2 should be deta 	Completed								24a. Was a autops perfor 1 Yes	sy	24b. Were auto prior to con death? 1 ☐ Yes	mpletion of caus	lable e of
Ĭ.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatier		/Outpatient	3□ DOA Ot	nar-		Check only or				
ion of	Jing After fune	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28	b. Time of Injury	28c. Inju	4 🗀 140.	280	d. Describe h		Other (Specify occurred	<i>(</i>)	
Divis		Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc.	(Specify)					City or Tow	n, State)	Number or Rura		,
	the Hospitel or hin 24 hours afte the Funeral Dir npletely filled in	edical	29a. Certifier 1 Certifying Processing One) 2 Medical Examples	ysician: To the best on niner: On the basis of and manner stat	examination	dge, death and/or inv	occurred at the trestigation, in my	me, date and opinion, deat	d place, and th occurred	d due to the c at the time, d	ause(s) a ate and p	and manner as st place, and due to	ated. the cause(s)	
	To th To th	Me	29b. Signature and title of certifies	. 1 01			29c. Licen	se number		2	9d. Date	signed (Month,	Day, Year)	
)	1		▶ Hmasic	www MI	<u>)-</u>		DL	463	346		4/:	10/06		
	Sta		30. Name and ad ress of person who 31. Date filed (Month, Day, Year)	a ma	ath (Item 23 ar's Signature	· Ke	Print)	end	e,51	ite:	100	Cumbe	tand,	MA
	Registr		APR 1 4 20	100	B	Goal	W						6	

			For State of Registrar	Maryland / Dep Ce	ertificate of			giene	6		15
A.	Physici	an	1. Decedent's Name (First, Middle, Last) Nancy Ellen Wells				2. Date of Dea Month March	30 Day 30 2006	Year	3. Time of E	Death M
24	/Medic Examin		4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town,	or Location of De		4c. County			
	LAGITIII	C1	Calvert Memorial Hospital	_	Prince F	rederic	k	Calve	rt		
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 1 ☐ M 2 1 ☐ F	7. Age (In yrs. last birthday	/) If Under 1 Year Months Days		Hrs. 8. Date of Birt (Month, Da Dec 18	y, Year)	Cou	place (State or intry) yland	Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	_ocation					10d. Inside City	/ Limits
	Maryl f sho	ğ	Maryland Calvert	Hunting	town					1 🗌 Yes	X □No
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of \	Vhat Cou	intry?	
	th wit	ai D	2410 Emmanuel Court		20639			United	State	es	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic avent, Ire Medical Exertificat most be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 Widowed 4 Divorced 12. Was Dece	2 🐴 No	. Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No		? (Specify Yes or No uerto Rican, etc.)	- 14. Rad Blad Specify	k, White,	ican Indian, , etc. ite	
Maryland 21215-0036	hin 72 hou an "natura Medical E	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	16a. Dec (Giv	edent's Usual Occur re kind of work done DO NDT use retire	upation e during most of ed)	working	16b. Kind of Br	ısiness/In	ndustry	
2	ed wit	Con	12	liqu	or store			Retail		s	
n D	be file	Be	17. Father's Name (First, Middle, Last)				Name (First, Middle,	Maiden Suman	10)		
Z	d Men narke	ဥ	Benjamin R. Brashears 19a. Informant's Name/Relationship (Type, Print)	tOb Ma	ling Address (Street		Akers Rural Route Number	or City or Tour	State 7	in Code)	
ā ≥	id 2 st Ith and 27 la r traur		George R. Wells - son				Juntingtow				
ē,	of Health a ltem 27 la		20a. Method of Disposition	20h Place of Dist	nosition (Name of		Date	20c. Location -			
E	Pages nent of h ant: If Ite ury or of		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	Metropol	ematory or other plants.itan Func	eral Ser	31 2006 Vice A	lexandr	ia V	irginia	Ĺ
Baltimore,	permit. Departir Importa any inju		21. Signature of Funeral Service Licensee	Rausch Fun rd. Port R	eral Ho Republic	me MD	20676				
	*		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	aused the death. Do not e						Approximate Interval Betw	een
9	Physician		Immediate Cause (Final disease or condition	Pulmona	~ L	odules				Onset and De	aath
- (42	/Medical Examiner		resulting in death) Due to (or as a consequence of):	0						
18	Ä	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	UTI						
	uted J ansit	min	Cause (Disease or injury	Renal	Mass						
Ć.	cate be executed bhysician and the burial-transit	Еха	that initiated events c	or as a consequence of):							
8760,	ite be iysicia ne bur	icai	d	Hyperc	alcon						
89	ntifica ng ph	Med	IF FEMALE:	—— <i>0</i> ·							
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	23b. Was decedent pregnant 1 Live bi	ant at time of death 5	☐Ectopic pregnand ☐ Other (specify)	cy			te of deliv Inth	-	ear
σ.	s that	by Pf	Part II. Other significant conditions contributing to de	ath but not resulting in the	underlying cause g	ven in Part I.	23e. Did to	obacco use cont	ribute to t	the cause of de	ath?
rds	w requires that been signed b should be deta	ed b	Cachesia				10	∕es 2□No	3 ☐ Pro	bably 4 🗇 🗸	known
006	law reas bee	Completed	MC				24a. Was		Were auto	opsy findings a	vailable
Ä	The lay ate has page 2	E					perto	rmed?	death? 1 🗌 Yes	20 No	236 01
/ita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				Death (Check only o	пө)			
of o	Physic this c	То Т	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ 11 27. Manner of Death 28a. Date of	npatient 2 ER/Outpatient 28b. Time	BIIL 3LI DOA		g Home 5 Resid	dence 6 Oth		ify)	
uo	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending (Month	h, Day Year) 200. Tille	W	ork? □Yes 2□No	200. Describe r	low injury occur	90		
Division of Vital Records,	Lor Attending Physician: after death. Director: After this certifica I in by the funeral director, p	Certification:	3 Suicide 6 Could not be	of Injury - At home, farm, s ng, etc. (Specify)			28f. Location (S City or Tox	Street and Numb vn, State)	er or Run	ral Route Numb	·
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the 2 Medical Examiner: On the ba	asis of examination and/or	ath occurred at the investigation, in my	time, date and pl opinion, death o	lace, and due to the occurred at the time,	cause(s) and ma date and place,	inner as s and due l	stated. to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier			nse number		29d. Date signe		-	
)			> D Shar MD		D	5029	0	3-3	0 -	06	
	3		30. Name and address of person who completed cause this see Shek	110, Hosp	RD		fred) MI	> <	20678	5
100	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1 2005	egistratis Signature	Sperte	P					

			1 - For State Registrar	State of Maryl	-	artment of rtificate o		nd Me		iene _{99. No.}	06	1187	6
П	Ph.	7	1. Decedent's Name (First, Middle, L	ast)				2.	Date of Deat Month	h Day	Year	3. Time of	Death
	Physici /Medio		MATTHEW	WARE Jr,				N	1ar		2006	9:10	AΜ
)"	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town	, or Location of	Death		4c. Co	ounty of Death		
			Southern Mary	land Hospit	al	Clin	ton			Pı	rince	Georg	
4	Funeral	3			yrs. last birthday)		ar If Under 2	Min. 8.	Date of Birth (Month, Day,		9. Birthi	lace (State or	r Foreian
	Director		424-58-3604	20	Yrs.		1100.0		lug 29		17 AI	abama	
	pu.		Usual Residence of Decedenl 10a. State 10b. County	100	. City, Town or Le							Od Incide Cit	
	aryła sho	-					-					l0d. Inside Cit 1 ☑ Yes	
	88-f	Funeral Director		George	MITCH	ellvil						1 163	2 110
	or 2	ä	10e. Street and Number			10f. Zip Code	9		1	0g. Citize	n of What Cou	ntry?	
	23a	ia	10017 Erion	Court,		207					U.S.A		
	eme	Ine	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Co	of Hispanic Origi uban, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)	14.	Race - Americ Black, White,	can Indian,	
စ္တ	or it	Ŧ	1 Never Married 2 Married	1 ☐ Yes 2 X Xo If Yes, Give		1 ☐ Yes Ž			,	S	pecify:		
Ö	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f show fre Modical Enaction Lusal by Dottling at	d by	3 Widowed 4 Divorced	Year or Dates:							В	lack	
Ϋ́	72 t	Completed	15. Decedent's (Specify only highest of	Education rade completed)	(Give	denl's Usual Occ kind of work dor	ne durina most d	of working		16b. Kind	of Business/In	dustry	
2	vithin han	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		aborer	ired)			~			
Ö	led v lygie her t	ပိ	11th Grade	-41		aborer	10 14-15-4	d. N			struc	tion	
Suc	be find the find of other finds of o	Be		,			_		First, Middle, N		rmame)		
Ž	ould Mer Parke	ို	Matthew Wa					an	Grah				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injuty or other treumatic event, the Medical Examiner metal by notified at once.		19a. Informant's Name/Relationship			ing Address (Stre				-		-	
	and lealth m 27 hsrt		Ava Singleton			17 Erio							<u> </u>
ore	of H ite		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3		b. Place of Dispo cemetery, cre			Date		20c. Loca	tion - City or To	own, Slate	
Ξ	Pag ment ant:		4 ☐ Donation 5 ☐ Other (Spec	city) R	essure	ction (Cem. 4	/1/0	6	Clin	ton, I	Md	
Baltimore,	port port y inj		21. Signature of Funeral Service Lic	nsee	2:	2. Name and Add	dress of Facility		TT		200	- 0	
m	89789		TROOK	Huruke	ula	246 N	en Fun Wash	inat	on St.	P.A Ro	. 208:	oU Le. Mo	1
۲			23a. Part1. Enter the disease, or co shock, or heart failure. List on	melications that caused the c	leath. Do not en	ter the mode of d	tying, such as ca	ardiac or re	espiratory arre	est,		Approximate Interval Belw	9
	Physician		Immediate Cause (Final disease or condition	(mn c	Pentry	0 HOC	ict 1	. ()	lure			Onset and D	
1	/Medical		resulting in dealh)	a. Due to (or as arcon	seguence of):	CHO	,						
A.	Examiner			(250	Dro-	Vasa	Mar	Ut	ade	7+			
	1.00	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a con	sequence of):								
	ate be executed hysician end the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Car	don	MOD	01/46	1					
a.	The law requires that the death certificate be executed tie has been signed by the attending physician end rage 2 should be detached for use as the burial-transit	Еха	resulting in death) Last	Due to (or as a con	sequence of):	01		1					
8760,	e be sicia e bur	dicai		d									
9	ificat g phy as the	edi											
Вох	leath certific attending pi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre						230	I. Date of delive	arv	
ŏ	eath atte	ciai	in the past 12 months?	1□Live birth 2□I 4□Pregnant at time		□Ectopic pregnar □ Other (specify)					Month	•	'ear
P.O.	that the de led by the a detached f	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown									
	that led b deta		Part II. Other significant conditions	contributing to death bul for	resulting in the u	inderlying cause	given in Part I.		23e. Did tob	acco use	contribute to the	ne cause of de	eath?
ds	sign d be	d by	Hoerte	nsion, U	Drona	WYH	steen	1	1 ☐ Ye	s 2 🗆 N	lo 3 ☐ Prob	ably 4 W	nknown
ŏ	w requires that been signed to should be det	Completed	di 600		-	1 *		<i>f</i>					
š	has has	m	orgease					_	24a. Was ar autopsy perform	y	4b. Were auto prior to co death?	psy findings a mpletion of ca	variable use of
<u> </u>	: Th	S								No		2 🗆 No	
Žį.	ician sertifi ector	Be	25. Was case referred to medical examiner?	- Line site is		- 1,		of Death (C	Check only one	9/			
<u></u>	Attending Physician: r death. ector: After this certifice by the funeral director, i	၉	1 ☐ Yes 2 ☑ No		2 ER/Outpatier	IL 3 DOA					Other (Specif	y)	
Division of Vital Records,	ing F Víter unera	Certification:	27. Manner of Death 1 ☑Matural 5 ☐ Pending	28a. Dale of Injury (Month, Day Yea	r) 28b. Time o	W			d. Describe ho	w injury o	ccurred		
Sio	Mtendi death. ctor: A y the fu	cati	2 Accident investigate 3 Suicide 6 Could not	ha			☐ Yes 2 ☐ No	lo					
Ξ	or At efter d Direct in by	E	4 Homicide determine		Al home, farm, sti <i>ecify)</i>	reet, factory, offic	æ	28f.	Location (Str City or Town	reet and N , State)	lumber or Rura	l Route Numb	oer,
	ital or rel D												
	Hosp 4 hou Fune ely fi	edical	(Check only 2 Medical Ex	Physician: To the best of my aminer: On the basis of exam	knowledge, deat nination and/or in	h occurred at the	time, date and	place, and	I due to the ca	use(s) an	d manner as s	tated.	
	To the Hospital or Attending Physician: The I within 24 Hours eliet death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Med	one)	and manner stated.									
	Son Son	~	29b. Signature and title of certifier	.1	_	29c. Lice	ense number	2	29	d. Date s	igned (Month,	Day, Year)	0
	7/		101101	navo m	D	100	1055	3/1	+ 0	13.	28	200	6
	(1)		30. Name and address of person where Sycveston Old	completed cause of death (Item 23a) (Type,	Print)	O Ces	CA	2 0	roal	HILL.	ma 2	nZi
			SYLVESTON UIL	W 1000, 017	LUNDA	10766 16	D/316		アノノ	~ U I V	11140)	702	74.
240	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	artes							

			_ 101	partment of Health and Me entificate of Death	_	ene 06	1877
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		Francis W. Warnock, Sr.		March 3	30,2006	7:30a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			1928 Old Elk Neck Rd.	Elkton		Ceci	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	ace (State or Foreign try)
	Director		143-28-2673 70	Φ.	ctober	28,1935	NY
	and		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		11	Od. Inside City Limits
	Maryl	ō	MD Cecil Elkton				1 □Yes 3 √□No
	28a	rec	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Coun	try?
	3a or	Funeral Director	1928 Old Elk Neck Rd.	21921		U.S.A.	
	death	Jera		Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Americ	
9	after or Ite	Ē	1 Never Married 2 Married Armed Forces? 1 Yes 2 No If Yes, Give	1 ☐ Yes 2€ No Specify:	iican, etc.)	Black, White, a Specify: Whi	
ဗ္ဗ	ours iral',	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	TE 103 QL NO Specify.		Specily. WIII	
21215-0036	within 72 hours after death with the Maryland one. than "natural", or Items 23e or 28e-f show the Model Examilied at	Completed	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	9	6b. Kind of Business/Inc	lustry
7	withir ane. than	du	Elementary/Secondary (0-12) College (1-4or 5+)	or Engineer		Communic	ations
р 2	filed Hygie ther		17. Father's Name (First, Middle, Last)	18. Mother's Name ((First, Middle, Ma		acions
Maryland	should be flied within and Menial Hygiene. s marked other than "sumatic event, I're Max	To Be	Alexander Warnock	Stella '	Walles		
ary	shound Mind Mind Mind Mind	-		ling Address (Street and Number or Rural		City or Town, State, Zip	Code)
	and 2 salth a n 27 is		Francis Warnock, Jr/Son 105	Medley Dr., News	ark, Di	E 19713	
ore,	ges 1 and 1 of He If item or other		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	ematory or other place) Ahril	te 20	c. Location - City or To	wn, State
<u>Ĕ</u>	Pages nent of ant: If it		'4 Donation 5 Other (Specify)	in The Januari		ed Hook,	NY
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Marical Examiliar in ast be multilized and once.		21. Signature of Fugeral Service Licensee Evange	ist ancem s of Facility Andrew G. Gee F	unoral	Home	
_	907 2 2 3		A All	259 E. Main St.	. Elkto	on, MD 2	1921
			23a. Part1. Exter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause in each line.	iter the mode of dying, such as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	y tailure			3 mo
	/Medical Examiner		resulting in death) Due ty or as a consequence of):	Mal li sa	0.1		1041
	Lamine		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	Obstructive	10/m	lonary 1	is easp
	led isit	Examiner	cause. Enter Underlying Cause (Disease or injury	,		*	
	xecui al-trar	хаг	that initiated events c				
8760,	cate be executed physician and the burial-transit	aiE					
189	ificate g phy as the	Physician/Medical	V.				
Вох	eath certific attending p I for use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	ry
	death e atte	icia		□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	at the by th tache	hys	9 Li Unknown				
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1	cco use contribute to th	
Vital Records,	w requir been si should	Completed	Diaveles Moderns	/ 2	1 Yes	2 No 3 Prob	ably 4 ∐Unknown
e C	law r as be	ηpie	Athroscherotic Cardiov	ascular Disease	24a. Was an autopsy	prior to con	psy findings available inpletion of cause of
<u> </u>	The ate h	Con			performe 1 ☐ Yes 2	ed? death? ZNo 1 ☐ Yes	2□ No
/ita	cian: ertific	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death	(Check only one)		
	Physical this call dir	2 2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	and the same of th	e 5 Resident	ce 6 Other (Specify)
L C	Jing After funer	ion	Natural 5 Pending (Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No	ou. Describe now	injury occurred	
Division of	Attendi death. ctor: A y the fu	fica	2 Accident investigation 3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, s		Bf. Location (Stre	et and Number or Rura	Route Number,
<u>S</u>	after after Dire	Certification;	4 Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, ar	nd due to the cau	se(s) and manner as st	ated.
	ne Ho ne Fu ne Fu	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred	d at the time, date	e and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, I	
•			Sanhara a Churcum	0 025415		3 30	06
	20		30. Name and address of person who completed cause of death (Item 23a) (Type	D D25415 .Print) 11 W. Highst Scit		- 11:1	- 7/0 -
	7		(Barbara A. Parky mp. 1	11 W. HIgNOT SUIT	K 214,	EIKNH, M	001721
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 2006 Market Signature				
	negisti	ui	LINE OF TOOL TOTAL				

			1 _ For		State	of Mai	ryland			ent of H ate of I	leaith and i Death	Mental Hy		7 1111	(5)	118	78
			Registrar 1. Decedent's Name	e (First, Middle,	Last)			Ce	lllica	ile or i	Jeani	2. Date of D	Reg. f	4o.		3. Time o	of Death
	Physic		FELIX P. ZY		,							Month MARCH		0ay 2006	Year	3:55	A M
	/Med Exam		4a. Facility Name (/		give street and nu	ımber)			4b. Cit	ty, Town, or	Location of Death			4c. County	of Death	3.33	A
			SUBURBAN HO	OSPITAL					BETH	HESDA			l _N	ONTGOM	ERY		
	Funera		5. Social Security N		6. Sex	7. Age	(In yrs. l	ast birthday)	If Unc	der 1 Year	If Under 24 Hrs. Hours Min,	8. Date of B	irth			place (State	or Foreign
	Directo		046-01-9114		1፟፟፟∭ M 2□F		88	Yrs.	IVIOITIII	Juys	TIOUTS IVIIII.	MAY 30,			CONNEC	CTICUT	
	and	7	Usual Residence of	Decedent 10b. County			10c. City	. Town or Lo	cation							Od. Inside C	hy Limite
	Aaryli Febo	٥	MARYLAND		DV		•										2 🕅 No
	the N 28a-	Director	10e. Street and Nur	MONTGOME	KI	1	POTOM	AC	10f. 7	Zip Code			100.0	Citizen of W	/hat Cour	ntry?	
	3a or		10004 HALL							20854				U.S.A.		, .	
	atter deeth with the Marylar or iteme 23a or 28a-f ehow	Funeral	11. Marital Status	KOAD	12. Was Dec	edent Ev	er in U.	S. 13.	_		ispanic Origin? (St n, Mexican, Puerto	pecify Yes or N	0-	14. Race	- Americ	an Indian,	
ď	after of the control	Ē	1 🗌 Never Marri	ied 2 Marne	Armed F ed 1 🛚 Yes If Yes, G	2 □ No		1		pecify Cuba : 2⊠ No	n, mexican, Puero Specify:	o Hican, etc.)			k, White,		
Ę	nours Fei	d by	3 💢 Widowed		Year or I	Dates:	WWII		1 🗆 1 63	20110	эрвену.			Specify	WHI	TE	
21215-0036	nat	Completed	(Spec	15. Decedent's ify only highest	s Education grade completed))		16a. Dece (Give	dent's Us	sual Occupa work done o	ation during most of worl !)	king	16b.	Kind of Bu	siness/In	dustry	
5	J within jiene.	m G	Elementary/Seco	ndary (0-12)	College ((1-4or 5+)		SURVEY		026 18(II.BO	7		TOL	IN OF G	DEENILI	TCU	
7	be filed tal Hygi d other	60	17. Father's Name	(First, Middle, L	ast)			BURVET	OK		18. Mother's Nam	ne (First, Middle				TOIT	
2	id be ental ked d		FRANK		ZYGMONT						MARY		CH	MIELOW	IEC		
Puelview	Itally Italia Z. I.Z. I.Z. COOO 2 should be filed within 72 hours after deeth with the Maryland 1 and Mental Hygiene. 1s marked other then "naturel", or Iteme 23a or 28a-f ehow raumatic event, Ital Madical Examinar must be notified at	-	19a. Informant's Na	ame/Relationshi	ip (Type, Print)			19b. Mailir	ng Addre	ess (Street	and Number or Ru	ral Route Numi	ber, City	or Town,	State, Zip	Code)	
	alth a		F. PAUL ZYO	GMONT, JR	./SON						POTOMAC, M	ARYLAND 2	20854	+			
ā	of He of He of He of He		20a. Method of Disp		3 □Removal from	State	20b. PI	ace of Dispo	sition (N	lame of or other place	e)	Date	20c.	Location -	City or To	wn, State	
<u>.</u>	Pag ment:	1		5 Other (Sp.		Jiaio	l	LINCOL			1	7/2006	BRE	MTWOOD	MARY	'LAND	
Raltimore	permit. Pages 1 and 2 should be Deperment of Health and Menta Important: if Item 27 is marked eny injury or other traumatic evonce.		21. Signature of Fu	neral Service L	icensee	•		H ²²	NES-1	ATRACTI	S FUNERAL H	OME, INC.					
	4 40500		CLIKE	anda	Jude	wig					PSHIRE AVE			PRING,	MARY		
			23a. Part1. Enter the shock, or hea		nly one cause on	each line.	e deam	. Do not ent	er the m	ioae or ayın	g, such as cardiac	or respiratory	arrest,			Approximation Interval Bet Onset and	tween
	Physician /Medical		Immediate Cause (disease or condition resulting in death)	rinai n				SEPSIS								24 HOUR	S
2 %	Examiner				Due to	(or as a	consequ	ence of):									
7		ē	Sequentially list contains. Enter Under Cause (Disease or	nditions.	b. — Due to	(or as a	Bonsaqu	unes of):							-		
, 1	cuted	Examiner	unau miniated events		c.												
9 9	ificate be executed g physicien and as the burial-transit		resulting in death) I	_ast	Due to	(or as a	consequ	ence of):									
3/06	ate b	edical		'	d										-		
	entific ding p		IF FEMALE:		220 H von ov	staama af											
A No.	eath certification of the second of the seco	ian	23b. Was decedent in the past 12	months?		birth 2	Fetal	death 3	Ectopic Other (pregnancy				23d. Date Mon		•	Year
Mo	The law requires that the death cert in the bash cert in the best been signed by the ettending bage 2 should be detached for use.	by Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9☐ Unkr		116 01 06	a 5_	J Other ((Specify)							
0	s that the	y P	Part II. Other signif	icant condition	s contributing to o	eath but	not resu	Iting in the u	nderlying	g cause give	en in Part I.	23e. Did	tobacco	use contri	bute to th	ne cause of c	death?
7	w requires to been signer should be	pa pa	ISCHEMIC CA	ARDIOMYOP.	ATHY, RENAL	L FAII	LURE,	AORTIC	STEN	NOSIS		1 🗆	Yes	2 🔯 No	3 🗌 Prob	ably 4 □I	Unknown
	aw re	Completed										24a. Wa		24b. W	ere auto	psy findings	available
13	The lay	E										auto perf	ormed?	d	rior to cor eath? Yes	npletion of o	ause of
/ Vital	ician: Th	Be	25. Was case reference examiner?	red to medical					-		26. Place of Deat						
77/2	Physician: r this certifice ral director, p	5	1 ☐ Yes 2 ☐					ER/Outpatier	nt 3 🗆 [4 Nuising m	ome 5 Res	idence	6 ☐Othe	r (Specif)	1)	
		ü	27. Manner of Death 1 ☑Natural	5 Pending		of Injury oth, Day	rear)	28b. Time of Injury		28c. Injury Work		28d. Describe	how in	ury occurre	d		
My	Attending or death. ector; After by the fune	cat	2 Accident 3 Suicide	investiga 6 ☐ Could no	nt he	4 t1			М		Yes 2 □ No	00/ 1	(2)	1.01			
22/2	· 호육등 =	Certification;	4 Homicide	determin	ned 286. Place build	e of injury ling, etc.	(Specify	me, farm, str)	eet, lacte	ory, office		28f. Location City or To	wn, Sta	and Numbe ite)	r or Hura	l Houte Num	lber,
2	Hospital 124 hours e Funerai I		29a. Certifier	1 X Certifying	Physician: To the	e best of	my knov	vledge, death	n occurre	ed at the tim	ie, date and place,	and due to the	cause	(s) and mar	ner as st	ated.	
1	To the Hosp within 24 ho To the Fund completely fi	Medical	(Check only one)	2 Medical E	xaminer: On the b	pasis of ea	xaminati	ion and/or in	vestigati	on, in my op	oinion, death occur	red at the time	, date a	nd place, a	nd due to	the cause(s	5)
	To the To the Comp	Σ	29b. Signature and	the of ogridier	1				2	29c. License	number		29d. D	ate signed	(Month,	Day, Year)	
				1	1 1	ND				D00601	17		MAR	CH 23,	2006		
	10		30. Name and addr	ess of person w	no completed cau	se of dea	th (Item	23a) (Type,	Print)								
	1		ERIC J. PAI	RK, M.D.,	9901 MEDIO				ROCK	WILLE,	MARYLAND :	20850					
	St Regist	ate trar	31. Date filed (Mon	MAR 27	2006	gistrar's	J Gigital	y A	asel	1							

			Type or Prin				k. Ensure Health and	•		9	
		1 - For State Registrar					of Death		Reg. No		
Physic /Med		1. Decedent's Name (First, Middle, La Richard Andrew A	·					2. Date of De Month APRIL	Da //		3. Time of Geath
Exami	iner	4a. Facility Name (If not institution, given SAINT AGNES HE)			4		n, or Location of Dea	ith	4c	. County of Deat	h
era			Sex 7. Ag	9 (In yrs. last b		If Under 1 Ye Months Da			y, Year)	Co	hplace (State or Foreig untry) yland
Maryland of show	tor	10a. State 10b. County	/4	10c. City, To		ation					10d. Inside City Limits
with the a or 28a be not	Director	10e. Street and Number 486 Brunswick St	woot			10f. Zip Cod	8		-	tizen of What Co	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic seent.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		IT Y	as Decedent	of Hispanic Origin? (Juban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)		ted Stai 14. Race - Ame Black, Whit Specify: Wh:	ncan Indian, e, etc.
d within 72 hours aff giene. er than "naturel", or the Medical Exem	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)			(Give kit	nt's Usual Oc nd of work do O NOT use re	ne during most of w	orking	16b. K	(ind of Business/	
be filed witl tal Hygiene d other the	Be	17. Father's Name (First, Middle, Last			areta!	ker		ame (First, Middle		metery Sumame)	
nd 2 should be file lth and Mental Hy 27 Is marked oth rtraumatic svent	To	Paul Arndt 19a. Informant's Name/Relationship (, ,		_		eet and Number or F				
es 1 and of Health litem 27		John Darpino Jr. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20b. Place	of Disposit	asning ion (Name of tory or other)	ton Blvd	Date 12 Ha		norpe, I	
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Physician /Medical Examiner portage prical-transit prical-t	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as	a consequence	e of):						Onsel and Death I WEEK 10 YEARS
Attending Physicien: The law requires that the death certificate r death. r death. ector: After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal deat		ctopic pregna Other (specify,			- Property Lands Adv Wilde	23d. Date of del Month	ivery Day Year
uires that t n signed by	þ	Part II. Other significant conditions (contributing to death be	ut not resulting	in the unde	erlying cause	given in Part I.	23e. Did t			the cause of death?
25 8	Completed							24a. Was autor perfo 1 Yes	an osy ormed? 252 No	death?	itopsy findings available completion of cause of
sicien; certific irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			25.001	?ther:	eath (Check only o			
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Ir	injury at Vork? Yes 2 No	Home 5 Resident			ofy)
To the Hospitel or Attendamin 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc		farm, street	t, factory, offic	C8	28f. Location (City or Tox			iral Route Number,
he Hospi n 24 hou he Funer pletely fill	Medical	29a. Certifier TS Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best on niner: On the basis of and manner sta	examination a	ge, death o	ccurred at the stigation, in m	time, date and place y opinion, death occ	e, and due to the surred at the time,	cause(s) date and) and manner as d place, and due	stated. to the cause(s)
To t To t	Ž	29b. Signature and title of certifier 7 Mwal	MD				7-605			te signed (Monti	
4		30. Name and address of person who TEO BORA H. NICULE	SCU, MA SA	HC, 900	CATOI	N AVEN	NE, BA	MORE, N	TARY	CAND, 2	1229
St Regist	ate	31. Date filed (Month, Day, Year) APR 1 7 201	\$2. Registra	r's Signature	Cont	U.	<u> </u>	,			

DHMH 17 Rev 1/2001

State Registrar

RICHARD A

ARNOT

		•	1 - For State Registrer	State of Maryland	/ Department of F Certificate of		lental Hygier	7 HIII	11880
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	D.	ALLEN		HPRIL C	Day Year	3. Time of Death 니다니 AM
	Examin Funeral	er	4a. Facility Name (If not institution, give Onion Memori 5. Social Security Number 6. Sec	ZIAL HOSPIY	aL Ba	If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye.	4c. County of Death	place (State or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County	1M 2□F 76	Yrs.		8-23-1	929 MAK	10d. Inside City Limits
	he Marylan 18a-f ehow ciffled at	ector	Mel	, , , , ,	Baltimo	re	1.00		1 ☑Yes 2 ☐ No
	s 23a or 2	Funeral Director			10f. Zip Code 2/2.			Citizen of What Cou	<u> </u>
900	72 hours after death with the Maryland neturel', or tteme 23s or 28s-f ehow dical Examil ar must be collified at	5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 Ø Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 ☑ No	Ispanic Origin? (Spe an, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Amer Black, White Specify: 6	
21215-0036	within ane. then	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired LongShor	during most of works d)	na	Kind of Business/li	ip Traile
Maryland	should be filed nd Mental Hygid marked other imatic event, II	To Be C	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ore	/	MARG	(First, Middle, Maid	63	
_	nd 2 s lith ar 27 io r treu		19a. Informant's Name/Relationship (Ty Southine MA)	thews Abben			Ave bu	Lto, Med.	21213
Baltimore	Pegenent ount: if int: if ury or		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from State	ee of Disposition (Name of letery, crematory or other place VIEW CRE MATE	any 4/11	106 B	Location - City or T	d.
Ball	permit. Per Department Important: any njury o		21. Signaturi of Fungfal Service Lie	all	22. Name and Addre	BROadu	vay bu	thogelite	2/2/3
ı	Physician /Medical		23a. Part1. Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Sepsis Syn	drome	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death 3 days
1	Examiner	-G	Sequentially list conditions, if any leading to immediate	Due to (or as a consequer Congestive Due to (or as a consequer	heart failure	2			2 years
8760,	ate be executed hysicien and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e Renal dis	ene			Zyeas
P.O. Box 687	ne death certific the attending pi thed for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{vs} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnancy	1		23d. Date of delik	ery Day Year
	w requires thet the been signed by should be detact	þ	Part II. Other significant conditions con	ntributing to death but not resulti	ng in the underlying cause giv	ren in Part I.		o use contribute to	. /
Il Records,	: The law re cate has be page 2 sho	Completed					24a. Was an autopsy performed 1 Yes 2 2	prior to death?	opsy findings available ompletion of cause of
Vital	sician: Tr s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 EF	VOutpatient 3☐ DOA Oth	ec.	(Check only one) me 5 ☐ Residence	S □Other (Same	4.1
ō	ding After fune	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		8b. Time of 28c. Injury Wor		28d. Describe how in		·y)
Division	2 th 12 c	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office		28f. Location (Street City or Town, St		al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir. completely filled in I	Medicai	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sicien: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the tirn n and/or investigation, in my o	ne, date and place, a pinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier Surveyor	.m.o.	29c. Licens	4389L		Date signed (Month	
,	29		30. Name and address of person who co			100 .	10		X00 6
0	<i>T</i> '		HINA CHARWR,		MEMORIAL 1-	-lospitaz	am,		
	Sta Registr		31. Date filed (Month, Pay, Year) APR 1 5 20	006 A Signatur	Sporter				

06-02488 Salvatore John E	Broc	hto S	tate o		nd / Dep	or Print in E partment of	Health and		giene			
Physicia		1- For State Registrar 1. Decedent's Name (First, Midd	lle,Last)		C	ertificate of	Death		2. Date of Death			3. Time of Death
Medical Exami	ner	SALVATORE	JOI	HN BR	OCATO				Month April 11, 20	Day Ye 106	ar	22:10
		4a. Facility Name (if not instituti	on, give	street and nun	nber)	4	b. City, Town, or L	ocation of Death	1	4c. County	of Death	
y de eq		102 Cedarcroft Road					Baltimore				N/A	
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs	s. last birthday)	If Under 1 Year		_	(MM/DD/YYY	Y) 9. Birth Cou	place (State or Foreign
Director		218-28-5936	1 X	M 2 F		73 Yrs.	Months Days	Hours Mir	May 23	, 1932		ryland
8		Usual Residence of Decedent			40- 0							40d Impleto City I Imple
w any		10a, State 10b. County			100, 01	ity, Town or Location	on					10d. Inside City Limits 1 X Yes 2 No
land f sho	ō	Maryland N/A				Baltimo						
Mary 28a-	Director	10e. Street and Number					10f. Zip Code		10	g. Citizen of W	/hat Count	ry?
1 the 3a or otifie		102 Cedarcrof	t Ro	ad				21212		U.S	.A.	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		12. Was Dece Armed For			Decedent of Hisp es, specify Cuban,				e - Americ te, etc.	an Indian, Black,
death or ite	5	20	Married .	1 X Yes	2 No		es, specify Cuban,	Mexicall, Foett	rican, etc./	*****		
after	by F	3 Widowed 4 D	vorced	If Yes, Give Year or Dates:	1952-5	55 1	Yes 2 X No	specify:		Specify	W	hite
ours		15. Decedent's Education (Sp	ecify on		e completed)		's Usual Occupati	on (Give kind of	work done	16b. Kind of B	lusiness/In	dustry
72 h	Completed	Elementary/Secondary (0-12)	College (1-	-4 or 5+)	during most of v	vorking life. DO N	OT use retired)				
O3(ш	12 years				En	treprene	ur		Res	staur	ant
5-0 led w tygic othe		17. Father's Name (First, Middle	e, Last)				1	8.Mother's Nam	e (First, Middle, M	aiden Surnam	e)	
21 be fill rked	Be	Charles Lewi	s]	Brocato				Sarah	Rose Di	Crispin	10	
21 ould d Mes s man	ဥ	19a. Informant's Name/Relation	ship (Ty	pe, Print)	(sist	er)9b. Mailing						
MD 12 sh th and 127 i		Sister Rosalie	Bro	ocato,	D.C.	333 S	outh Set	on Aven	ue Emmit	sburg,	Mary	land 21727
Heal		20a, Method of Disposition				 b. Place of Disposi crematory or oth 		netery,	Date	20c. Location	- City or T	own, State
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		1 X Burial 2 Cremation	_	Removal fro	om State N	ew Cathe		etery 4	-18-06	Baltim	ore	Maryland
Iting it. Partition of the property or		4 Donation 5 Other 3 21. Signature of Funeral Service		:00	1			-				-
Ba perm Depa Imp		Of 1 C	o d d	-		M	itchell-	Wiedefel	d Funera Baltimor	ıl Home	, Inc	
	9	23a. Part I. Enter the risease, of	r compl	ications that ca	used the dea	i (DOUU YOU	K Road	Raltimor	e, Mar	yland	1_21212 Approximate Interval
Physicían /Medical		failure. List only one caus	e on ead	ch line.					or respirately arre	ot, 0.1.00.1, 0.1.1		Between Onset and
(Examiner		Immediate Cause (Final diseas or condition resulting in death)				sclerotic Cardi	ovascular Dis	ease				Death
Andrew		or condition resulting in death)		Oue to (or as a	consequenc	e of):						
	-	Sequentially list conditions, if any, leading to immediate	b. Г	Due to (or as a	consequenc	e of):						
	Ë	cause. Enter Underlying Caus										
1 _ =	Examine	(Disease or injury that initiated events resulting in death) Last	7	Due to (or as a	consequenc	e of):						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	calE		d.		001	0.	-/ / 47 /	26				
e exe	dica	UNPENDED		AMENDED	29d p	er me g8!)4 4-I/ - (<i>y</i> t				
68760, certificate be rding physici se as the buri	Physician/Medi	IF FEMALE:		23c. If yes, c	outcome of pi	regnancy				23d. Date	of delivery	
striffic rrtiffic ling p	an/	23b. Was decedent pregnant in past 12 months?	the	1 Live b			tal death 3	Ectopic pregr	ancy	Month	D	ay Year
or use	ij		nknown		ant at time of	f death 5 Oti	ner (Specify)					
Box te death c the atten	Ę			9OIKIO								
hat the	by P	Part II. Other significant cond	itions	contributing to	death but no	ot resulting in the u	inderlying cause g	iven in Part I.				he cause of death?
ires the signe									1 Yes	2 No :	3 Prob	ably 4 🗸 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed								24a. Was a autops			opsy findings available empletion of cause of
co e law e has	ш							**	perform	ned?	death?	
tal Rection: The certificate							00 Di	-6 D 11: (O):1		No No	1 Ye	s 2 No
Vital Rec ysician: The l his certificate director, page	Be	25. Was case referred to medic examiner?		ospital:				of Death (Check Other:4 Nurs		Danislanaa 6	o di Oah oo	S
hysical directions of the second seco	2	1 ✓ Yes 2 No		""	npatient 2	ER/Outpatient				Residence 6		Scene
1 of Jing Ph. After the funeral		27. Manner of Death 1 ✓ Natural 5		28a. Date (Month,	of Injury , Day,Year)	28b. Time of la		y at Work?	28d. Describe h	ow injury occu	rrea	
ior: the tor:	atic	j Pe	nding estigatio	on			1 1	res 2 No				
Division tal or Attendir is after death.	Certification:		uld not b	28e Place	e of Injury - A	t home, farm, stree	et, factory, office b	uilding, etc.	28f. Location (S or Town, St		ber or Rur	al Route Number, City
oital ours a illed	ert	4 Homicide de	ermined	(Specify)					or rown, se	ate)		
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director. A		29a. Certifier 1 Certifying	Physici	an: To the bes	t of my know	ledge, death occur	red at the time, da	ite and place, an	d due to the cause	e(s) and mann	er as start	ed.
thin thin or the	Medical	one) 2 Medical Ex	aminer	On the basis of and manner st		n and/or investigat	ion, in my opinion	, death occurred	at the time, date a	and place, and	due to the	e cause(s)
£ 3 £ 8	Ne S	29b. Signature and title of certif	ier	and marmor of			29c. License	e number		29d. Date sig	ned (Mor	nth, Day, Year)
		Carre	HA	00a	1		O.C.I	M.E.		April 12,	2005	
		200 00 0	UU			10m 23c1						
10		30, Name and address of personal Allan, M.D.		completed caus ant Medica			Street, Baltin	nore. MD 21	201			
'			-1	32 D	gistrar's Sign		Jacob Daidi					
St Regis	tate trar	31. Date filed (MonR, PR Year	72	006	giou ai o oigr	M L	all s					
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			For State Registrar	i iouso	State of			/ Depa		t of H	ealth a		lental H		7111	6	11882
	Physici	an	Decedent's Name (F JANE SF		st) BEHRENS								2. Date of Month		² 2006	Year	3. Time of Death
1000	/Medic Examin	al	4a. Facility Name (If no The Wesle	t institution, giv		mber)				Town, or alti	Location o		April		4c. County		I I AM M
	Funeral Director		5. Social Security Number 212–12–7636	per 6. 9	Sex 1 □ M 2 X X	7. Age (/ 87	n yrs. las	t birthday) Yrs.	If Under Months		If Under 3	24 Hrs. Min.	8. Date of Month,	Birth Day Yea		9. Birth	place (State or Foreign
			Usual Residence of De	cedent b. County		11	Dc. City.	Town or Lo	cation								10d. Inside City Limits
	Maryla	ţ		N/A				imore									1 ∑Xes 2 □ No
	h with the	Funeral Directo	10e. Street and Number 2211 West		Avenue				10f. Zip		208			10g.	Citizen of W	hat Cou	ntry?
036	iled within 72 hours after death with the Maryland Hygiene. uther than "netural", or Iteme 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 3 Widowed 4	_	12. Was Dec Armed For 1 Tyes If Yes, Gi Year or D	2XXVo	er in U.S.		Was Deced f Yes, spec 1 TYes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or Rican, etc.)	No-		c, White,	can Indian, etc. White
9500-61212	within 72 hours ene. than "netural", ne weden Ex	Completed	(Specify (Elementary/Seconda		ducation ade completed) College (1-4or 5+)		16a. Deced (Give life.	dent's Usua kind of wo DO NOT us Home	rk done d se retired,	luring most)	of worki	ing	16b.	Kind of Bu	siness/in	•
yland 2	uld be filed Mental Hygi irked other atic event, I	To Be Co	17. Father's Name (Fine Douglas Ala	st, Middle, Las							18. Mothe		eid Hu		len Sumame		
Z Z	and 2 sho sath and t n 27 is me er traums		19a. Informant's Name Douglas Bel		Type, Print)	Sor		16235	5 Hut	chin:	s Mil		ad Mor				Code)
Baltimore,	permit. Pages 1 and Deparment of Health Important: If Item 27 any in ury or other ti		20a. Method of Disposi 1 Burial 2XX0 4 Donation 5	remation 3 [□Removal from	State		ce of Disponetery, crem				/18/	oate 06		Location - 0		own, State Maryland
gall	Depart Depart Importa any ins	,	21 Signature of Funer	al Service Liv	Enas	les	_	22	l. Name ar	d Addres							Home Inc land 21212
<u>}</u>	Physician /Medical Examiner		23a. Part1. Enter the c shock, or heart ta tmmediate Cause (Fin disease or condition resulting in death)	-	a A	cute	St	whe	,					arrest,			Approximate Interval Between Onset and Death
9/90,	te be executed ysician and te burial-transit	dical Examiner	fe any, leading to imme cause. Enter Underlyin Cause (Disease or inju- that initiated events resulting in death) Last	ions idiate ng ry	c.	(or as a c	onseque	nce of):	Va	ceu	an) JUS	Pase				
O. Box 68	The law requires that the death certificat Ne has been signed by the attending phy page 2 should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent print in the past 12 mo 1 □ Yes 2 ☒ N 9 □ Unknown	nths?		oirth 2 (nant at tim]Fetal d	eath 3	Ectopic pr						23d. Date Mon		ery Day Year
rds, P	w requires that the de been signed by the should be detached	ed by Pr	Part II. Other significant Coronary	nt conditions artin	and .			ing in the u		- m		gin	1			bute to t	he cause of death?
Vital Records		Completed	Anemo	<u>`</u>										itopsy informed	7 g	ere autorior to constant	opsy findings available impletion of cause of
VII	Physician: The la this certificate ha al director, page 2	o Be	25. Was case referred examiner?	to medical	Hospital:		400.61	2/0		Othe	_		Check on				
on or	Phy this ald	-	1 ☐ Yes 2 S No 27. Manner of Death 1 S Natural 2 ☐ Accident	☐ Pending investigation	28a. Date (Mor	Inpatient of Injury oth, Day Y	2	Outpatien Bb. Time of Injury		8c. Injury Work	at Nu		me 5 Re 28d. Describ				(y)
DIVISION	0 # D is	Certification:		Could not to	28e. Place	of Injury ing, etc. (· At hom Specify)	e, farm, str	eet, factory	, office	-			n (Street Town, St		or Run	al Route Number,
	- LA - 0	Medical C	29a. Certifier 15 (Check only 25 one)	Certifying P Medical Exa	hysician: To the miner: On the b and mar							L					tated. o the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title	of certifier	0 _0				290	License	number			29d. I	Date signed	(Month,	Day, Year)
,	'0/		30. Name and address	of person of	completed cau	se deat	h (Item 2	3a) (Type	Print)	VZ	1469				4/1	1106	>
_	10	1	ROBERT D	Bert	on mo	. 35	03	BAN	h ST	B	MIT	0, 1	rul	2	122	4	
	Sta Registr		31. Date filed (Month, I		2006	distrar's	Signatui گر ست	k a	perth	,			ed at the tim			,	

			1 - For State Registrar	State of Maryla	nd / Dep	ertificate of	lealth and	Mental Hygi	•	11883
40	Physicia	an	1. Decedent's Name (First, Middle, L	ast) Bernard	т	Bush		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, g	ive street and number)	Rock	4b. City, Town, o	r Location of Deat	we	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 212–48–2191 Usual Residence of Decedent	Sex 7. Age (In yrs 57	Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 12-31-	9. Bir	rthplace (State or Foreign ountry) Md
e Marytand	a-f show	ctor	10a. State 10b. County Md N		ity, Town or l Balto	ocation				10d. Inside City Limits YYes 2 □ No
th with th	23a or 28 ust ke no	al Director	10e. Street and Number 3905 Essex Road			10f. Zip Code 2120)7	10	g. Citizen of What C	ountry?
1 215-0036 within 72 hours after death with the Maryland	natural', or Items 23a or 28a-f show Jical Exercit et must be mutified at	by Funeral	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates:	J.S. 13	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (San, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am- Black, Whi	
21215-0036 3d within 72 hours af	pene. r than *natu	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12th grade	Education rade completed) College (1-4or 5+) 4 Vears	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retired	during most of wo	rking	6b. Kind of Business Rumpper,	Kemper,Karl
Maryland 2 nd 2 should be filed	la de	To Be C	17. Father's Name (First, Middle, Last Pumeroy Bush	(1)			Ruth Tu			
Brown .	f Health and Meritem 27 is marke		19a. Informant's Name/Relationship Delores Bush - S			ling Address (Street)5 Essex R		ral Route Number, .to,Md 212	City or Town, State, .	Zip Code)
Baltimore,	2=2	ĺ	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, cre	osition (Name of ematory or other place) Forest V	1		Oc. Location - City or Owings Mi	
Balti Permit	Departmen important: •ny injury once.		21. Signety of Funeral Service Lice		1	22. Name and Addre	ss of Facility M	larch F/H	West	
3 J	ıysician Medical xaminer		23a. Part / Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	nplications that caused the deay one cause on each life. a. Due to (or as a conse	intra					Approximate Interval Between Onset and Death
760, te be executed	rysicien and he burial-transit	licai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse		su.				Miknown
Box death cert	ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
	engi pe q	۵ ک	Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause giv	en in Part I.			the cause of death?
al Reco		Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	utopsy findings available completion of cause of
of Vita Physician:	w =	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Impatient 2	ER/Outpatie	ent 3 DOA Oth	or	th (Check only one	ce 6 Other (Spe	
Vision Attending	h. After fune	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident 6 Could not 4 Homicide determine	28a. Date of Injury (Month, Day Year) on be 28e. Place of Injury - Ath	28b. Time of Injury	of 28c. Injun Work	y at	28d. Describe how	v injury occurred	
Div Hospital or	within 24 hours after deat To the Funeral Director; completely filled in by the	edical Cert	29a. Certifier 1	building, etc. (Specifyscian: To the best of my kniminer; On the basis of examin	owledge, dea	th occurred at the tin	ne, date and place	City or Town,	ISO(S) and manner as	s stated.
To the	within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licenso			d. Date signed (Mont	
nt	1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	, Print) _	4322	0 00	me 12	1 Mindine 1
U CONTRACTOR	Sta	te	31. Date filed (Month, Day, Year)	2 2006 32. Registrar's Sign	ature	to the	57	metin	ue fa	et. his zizis

DHMH 17 Rev 1/2001

Registrar

APR 1 7 2006

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** PATRICIA J. BROWN APRIL 13, 2006 10:30 AM. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1632 YAKONA ROAD BALTIMORE TOWSON
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Months Days Hours Min Yrs. Director 217-64-4402 12/27/1953 MARYLAND Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 1632 YAKONA ROAD USA deeth v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Flementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE MANAGER VIDEO STORE 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny fulury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be MEREDITH BAKER ELEANOR STREETI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. DANIEL BROWN/HUSBAND 1632 YAKONA ROAD TOWSON, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 OCremation 3 □ Removal from State METRO CREMATORY, INC. 4/18/2006 4 □Donation 5 □ Other (Specify) CATONSVILLE, MD 21. Signature of Funeral Senfice Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 part. Enter the disease, or compleations that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0000 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1000 S1 autopsy performed 2X No t ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 7 2006

2. Registrar's Signature

			For State Registrar	State of N	Marylan			of Health of Death			giene Reg. No.	06	40000	86
	* 2 . 2		Decedent's Name (First, Middle	, Last)						2. Date of De. Month	ath Day	Year	3. Time	of Death
	Physici /Medio Examin	al	Joseph A. Berg		r)		4b. City, To	wn, or Location	of Death	April	11,	2006 county of Deat	10:00) p. M
			2732 Albert Ri				West	minster				Carrol		
	Funeral		5. Social Security Number	6. Sex 7. / 1 1 1 M 2 □ F	Age (In yrs. : 98	last birthday) Yrs.	If Under 1 Y Months D	ear If Under ays Hours	Min.	8. Date of Bird (Month, Da	y, Year)	Co	hplace (State untry)	
	Director	}	213-07-7383 Usual Residence of Decedent		90					Mar. 1	.0, 15	908 N€	w Jers	sey
	show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside	
	Sa-fs	cto	Maryland Carr	oll	W€	estmins	ter						1 ∐ Y€	s 24_XNo
	hours after death with the Maryland tural', or Itama 23a or 28a-f show at Examinate be neitlied at	Funeral Director	10e. Street and Number				10f. Zip Co	ode			10g. Citize	on of What Co	ountry?	
	s 23s	erai	2732 Albert Ril	l Road_ 12. Was Deceder	of Ever in II	C 13 V		1157	igin? (Spe			d Stat		
	ter de	Ē	11. Marital Status 1 □ Never Married 2 □ Marri	Armed Force	s?			t of Hispanic Or Cuban, Mexica	n, Puerto	Rican, etc.)		Black, Whit		
936	urs a	Ď	3	If Yes, Give Year or Dates		V 1	1□Yes 2【X	No Specify	:		S	Specify: Wh	te	
215-0036	72 8 3	Completed	15. Decedent (Specify only highes			(Give	dent's Usual C	done during mos	st of workii	ng	16b. Kind	d of Business/	Industry	
2	within ene. then "	m m	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT use i	· ·			_			
121	filed with Hygiene other the		6 years 17. Father's Name (First, Middle, I	asri		Mast	er Ele	ctricia		(First, Middle,		rical	Contra	actor
Maryland	8 <u>a</u> 8) Be	John Bergenbac							te Carı		arriamo,		
Z	2 should and Men Is marke eumatic	2	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (S	treet and Numb				Town, State, 2	Zip Code)	
	12 mg		Ronald L. Berge	nback (son	1)	2732	Alber	t Rill :	Road	West	minst	er. Ma:	rvland	21157
Baltimore,			20a. Method of Disposition	2 - D	_	Place of Dispo	sition (Name	of		ate		ation - City or		
Ē	Pages nent of I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation / ☐ Other (S)	3 □Removal from Star pecify)	(e/)			m. Park	4/1	5/06	Dors	ey, Ma:	rvland	
att	permit. Page Department of Important: If eny Injury or once.		21. Signature di Funeral Service I	iagaspe	1/1/1	/// 22	. Name and A	Address of Facil ck Fune:	ity			_	_	
8	20E 29		nell		W//	7	922 Wi	se Aven	ue D	undalk,	, Mar	yland	21222	
			23a. Pagt. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the death line.	h. Do not ent	er the mode o	f dying, such as					Approxim Interval B Onset an	etween
1. 192	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a	on	gest	we	Hear	to	tailu	ve		34	5
	/Medical Examiner		resulting in death)	Due to (or a	asia consed	vence of):	Clo.	1020					-	
Н		7	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a conseq	uence of):	stenc	1515					39	13
	nsit	n L	cause. Enter Underlying Cause (Disease or injury	•	,									
Ć.	sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or a	as a conseq	uence of):								
190	w > w	cai	-	d										
89			IF FEMALE:											
Вох	The law requires that the death certifica tie has been signed by the ettending phoage 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	Ideath 3□	Ectopic pregi				23	ld. Date of del	ivery Day	Year
-	the el	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐ Unknown		eath 5	Other (speci	fy)				111011111	Juj	
P.0	that the de ned by the e detached t		Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	nderlying caus	se given in Part	l.	23e. Did f	obacco use	e contribute to	the cause o	f death?
Records,	ulres that signed I	d by	Dem	entia						10	Yes 2. ☑	No 3 □ Pr	obably 4 [Unknown
Š	w requir	Completed								24a. Was	an	24b. Were au	itopsy finding	is available
Re	he lav e has age 2	d E C									osy ormed?	prior to death? 1 ☐ Yes	completion of	cause of
of Vital		BeC	25. Was case referred to medical					26. Plac	e of Death	1 ☐ Yes (Check only o	2/2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 □ No	
\	Physician: this certificanal director, I	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	afient 2	ER/Outpatier	it 3□ DOA	Other: 4 N	ursing Hor	ne 5 🖸 Resi	dence 6	□Other (Spe	city)	
	ding Pt. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pendin	28a. Date of In (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury	28c	. Injury at Work?		28d. Describe				
Division	Attending r death. ector: After by the fune	Certification:	2 Accident investig	pation			М	1 Yes 2						
Ν	l or Atteno after death Director: I in by the	il il	4 Homicide determ	inod 286. Place of	Injury - At ho etc. (Specif	ome, farm, str 'y)	eet, factory, o	ffice	1	28f. Location (City or To	Street and wn, State)	Number or Ru	ural Route Nu	ımber,
	Hospitel 24 hours a Funeral I		29a. Certifier 1 Certifyin	g Physician: To the be	et of my kno	wieden deat	a occurred at	the time, date a	nd place :	and due to the	Called(e) a	nd mannor as	stated	
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medicai	(Check only 2 Medical one)	Examiner: On the basis and manner	of examina	ation and/or in	vestigation, in	my opinion, de	ath occurr	ed at the time,	date and p	lace, and due	to the cause	e(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	-m//			29c. L	icense number			29d. Date	signed (Mont	h, Day, Year,	1
			1 Copert	7 Ullar	V		17	3429	18		4-	-12-	200	6
	011		30. Name and address of person	who completed cause o	f death (Iten	n 23a) (Type,	Print)	1 01			ſ	3		
	V1 3		Robert N. Ko	185, M.D.	410	Mala	olm k	Ir. Ste	- C	West	men	eter,	4D 2	4157
71 5	Sta Regist		31. Date filed (Month, Pay Year)	7 2006 32. Agi	strar's Signa	ature	ale	icense number 3429)r. S.K						

11887

1 - For State Registrar

THUMAS G. BARNES

7	Physici	an	Decedent's Name (First, Middle, Last) Thomas County in the County	Damas	-			2. Date of De Month	Day Year	3. Time of Death
	/Medic Examir	cal	Thomas Garrison 4a. Facility Name (If not institution, give st			•	Location of Death	APRIL	4c. County of Dea	, , , ,
	*	gille.	Good Samaritan Ho		and the second	Bal .	timore If Under 24 Hrs.	100 (8)	N/A	
	Funeral Director		5. Social Security Number 6. Sex 216-20-1055	M 2□F 81	yrs. last birthday) Yrs.	Months Days	Hours Min.	B. Date of Bir (Month, Da Feb. 2,	1925 Mary	thplace (State or Foreign ountry) Land
	yland		10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside City Limits
	e Mar Ba-f st	ctor	MD N/A		Baltimor	е				1√ Yes 2 No
	h with th	ai Dire	10e. Street and Number 5906 Belle Vista	Avenue		10f. Zip Code 21206			U.S.A.	ountry?
220	be filed within 72 hours after death with the Maryland tail Hygiene. od other then "natural", or items 23s or 28s-f show event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever if Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WW I	!	Was Decedent of H f Yes, specify Cuba □ Yes 2√2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
5	72 hou		15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	tent's Usual Occup	ation during most of work	kına	16b. Kind of Business	Industry
7 7 7	2 should be filed within and Mental Hygiene. Is marked other then "aumatic event, the Mas	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	nsurance	1)	g	Insuranc	e Company
2	tal Hyg	Bec	17. Father's Name (First, Middle, Last)						Maiden Sumame)	
7	d Meni	^L O	Thomas Garrison B		105 14-15-	- Add (Ctt		Pilker		7-0-4-1
2	id 2 st lth and 27 is r traur		19a. Informant's Name/Relationship (Typ Jeanne Y. Barnes-						er, City or Town, State, I	
ָ ט	s 1 ar f Heal ftem 2		20a. Method of Disposition	20	b. Place of Dispo		1	Date	20c. Location - City or	
2	Page nent o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		Cemetery	1	7/06	Baltimore,	Maryland
	permit. Pages 1 and 2 should by Department of Health and Ments Important: If Item 27 is marked any injury or other traumatic e <u>poce.</u>		21. Signature of Funeral Service Licensed	Heather (l. Ruck, Indore, Maryland	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line					CONTRACTOR DESCRIPTION OF	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	CIMUNU Due to (or as a con		nnn	FBWS	15		Onset and Death
,000	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a con						
O. DOA O	he death certific the attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 Live birth 2 If 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
	that the	y Ph	Part II. Other significant conditions cont	nbuting to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
, ,	quires an sign uld be	ed by	EMMML UBSDRU	1 CAVE L	MG DI	SUME		10	Yes 2 No 3□Pi	obably 4 Unknown
	sician: The law requires that the de certificete has been signed by the irector, page 2 should be detached	Completed	Pulmunmy 1	HUNER DON	15100		-	24a. Was autor perfo	osy prior to death?	utopsy findings available completion of cause of 2 No
212	ician: sertific ector,	Be	25. Was case referred to medical examiner?	espital: 🗸		l Oth	26. Place of Dear	th Check only o	one)	
5	ing Phys	lon: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injun Wor	y al k?		dence 6 Other (Spe	cify)
710171	l or Attending Physication death. Director: After this in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp			Yes 2 □ No	28f. Location (S City or Tox	Street and Number or Ri wn, State)	ural Route Number,
J	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	Medical Ce	29a. Certifier Certifying Physic (Check only one)	er: On the basis of exam	knowledge, death	occurred at the ting	ne, date and place, pinion, death occur	and due to the	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	o the o mple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (Mont	h, Day, Year)
)	->-0		I Amin / 1	mo		D151	35		APRIL 13,	2006
	104,		30. Name and address of person who con	mpleted cause of death	(Item 23a) (Type,	Print)	NEIMO	212	34	
3	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	lignature	1 45	17.19	012		-
	Registi	rar	APR 1 7 2	NEN 3 L 32. Registrar's S	, S. A.					
DHI	MH 17 Rev 1/2	001		5	100					

DHMH 17 Rev 1/2001

06-02420 Bratley, Andre Physician/ Medical Examiner

1- For State

1. Decedent's Name (First, Middle, Last)

Sinai Hospital

Andre R. Bratley Jr.

4a. Facility Name (if not institution, give street and number)

Registrar

Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	_			B. Date of Bir	th (MM/DD/		nplace (State or Foreign intry)
Director		218-11-0751	1 X M 2 F	20	Yrs.	Months	Days	Hours	Min.	05-01-1	1985	Mary	' -
ě.		Usual Residence of Decedent		1.0									
w any		10a. State 10b. County		10c. City	, Town or Locatio								10d. Inside City Limits
Maryland 28a-f show d at once.	ţō	MD	NA		Balt	imore							1 X Yes 2 No
e Mary or 28a	Director	10e. Street and Number				10f. Zip Co	de			1	0g. Citizen	of What Coun	try?
ith the Maryland 23a or 28a-f sho notified at once.		3913 Chatham Roa	-				1207					USA	
D 21215-0036 shours after death with the Maryland and Mould Hygien with 72 hours after death with the Maryland and Mould Hygien 1; is marked other than "natural", or items 23a or 28a-f 5th or items the Medical Examiner must be notified at once	by Funeral		Married Armed F	2 X No	If Ye	s, specify C	uban, I	Mexican, F	n? (Specit Puerto Ric	fy Yes or No an, etc.)		Race - Americ White, etc.	an Indian, Black,
s afte	þ		vorced If Yes, Give Ye or Detes:			Yes 2 X					Spe	ecify: Bla	ck
2 hour	ted	15. Decedent's Education (Spe			16a. Decedent's during	s Usual Occ	upatio	n (Give kii	nd of work	done	16b. Kind	of Business/Ir	dustry
0036 within 72 jiene. er than '	ble	Elementary/Secondary (0-12)	College (1-4 or 5+)		orking life. [T use retir	red)				
21215-0036 Modd be filed within 72 hours ahe marked other than "natural?", or event, the Medical Examiner	Completed	17. Father's Name (First, Middle	Last)		II.	stalle:	_	Mother's	Name /Fi	rst, Middle, I	Maidan Sur	Furnit	ure
215 e file tal Hy ked o	Be (Andre Bratley S	. ,				'	viotrier 3		een Ste		name)	
21215 buld be fill I Mental H marked ic event, t	0	19a. Informant's Name/Relations			19b. Mailing	Address (S	Street a	and Numb				r Town, State,	Zip Code)
	Ė	Maureen Jones/	Mother							re, MD		,	,
ore, MC es l and 2 sl of Health ar If item 27		20a. Method of Disposition			Place of Dispositi	on (Name o				ate	-	tion - City or 7	Γown, State
not le la la la la la la la la la la la la la			n 3 Removal fi	om oldio	crematory or othe codlawn Ce				04-17-	06	LTo a d'	1 MD	
		4 Donation 5 Other S 21. Signature of Funeral Service		AAC		me and Add	iress o		04-17-	-06	DOOM.	lawn, MD	
Balt permit. Depart Import injury		Lunella	Janes	\supset				,	638 N	Ci Imo	r Stro	at Ralti	more, MD 21217
Physician		23a. Part I. Enter the disease, or	complications that c	aused the death	. Do not enter the	mode of dy	ing, su	ich as car	diac or res	spiratory arr	est, shock, o	or heart	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease		ınshot Wour	nds								Between Onset and Death
Examiner		or condition resulting in death)		consequence of									
		Sequentially list conditions,	b										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		consequence of	of):								
	am	(Disease or injury that initiated events resulting in death) Last	C	consequence of	of):				-				
cuted nd transit	ω		d.										
e exec	Jica	UNPENDED	AMENDED	,									
ds, P.O. Box 68760, equires that the death certificate be executed een signed by the attending physician and ould be detached for use as the burial - transit	Physician/Medical	IF FEMALE:	23c. If yes,	outcome of preg	nancy						23d. Da	ite of delivery	
68 certific dring	ian	23b. Was decedent pregnant in the past 12 months?	Live	oirth nant at time of	2 Feta	I death	3	Ectopic p	regnancy		Mor	nth Da	ay Year
SOX Jeath e atter for u	ysic	1 Yes 2 No 9 Un	known 9 death Unknown		5 Othe	er (Specify)							
tthe carby the		Part II. Other significant condit			esulting in the un	derlying cau	se giv	en in Part	1.	23e. Did to	bacco use	contribute to the	ne cause of death?
ds, P.O. equires that the een signed by ould be detach	b y												ably 4 Unknown
ds, equir	eted								_	24a. Was a			opsy findings available
COF law r has b	Jdu.									autop perfor	sy	prior to co death?	impletion of cause of
Re : The ificate r, pag	Comple									1 Yes		1 🗸 Yes	2 No
Division of Vital Recortal or Attending Physician: The law Is a safter death. al Director: After this certificate has I led in by the funeral director, page 2 sh	Be	25. Was case referred to medica examiner?	Hospital:		FD/0			Death (C					
of V ; Phys rer thi	၉	1 ✓ Yes 2 No 27. Manner of Death		of Injury	ER/Outpatient 28b. Time of Inju			at Work?	Nursing Ho		Residence		
nding th.	io	1 Natural 5 Pend	28a. Date (Month Apr 8, 2	Day,Yeer)	20:00	1		2 N	Sid	I. Describe t bject sho	t	ccurred	
isic Atte er dea rector	icat	2 Accident Inve	stigation 28e Plac	e of Injuny - At by	ome, farm, street,	factory offic				Laarting (C			15 . 11 . 6
Div tal or is after led in	Certification:		d flot be	Sidewalk	Jine, laim, Street,	ractory, onn	ce buil	ung, etc.		or Town, St	tate)	ve, Baltim	al Route Number, City
Hospi 4 hou Funes ely fil	<u>o</u>	20a Cotifica	hysician: To the bes		ne death occurre	d at the time	date	and place					
Division of Vital Records To the Hospital or Attending Physician: The law requivisitin 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Medical		miner:On the basis	of examination a	nd/or investigatio	n, in my opii	nion, d	eath occu	rred at the	time, date	e(s) and ma and place, a	and due to the	cause(s)
7.≥ ₹ 8	Se Se	29b. Signature and title of certifie	and manner s	tated.		29c. Lic	ense n	umber			29d. Date	signed (Mont	h, Day, Year)
		7-1 011	10 × A	-		0.	C.M.	E.			April 9,		
d	1	30. Name and address of person	who completed caus	e of death (Item	23a)								
3			Assistant Medic		111 Penn	Street, B	altim	ore, ME	21201				
St	ate	31. Date filed (Month, Day, Year)	32. Re	grstrar's Signatu	re	913 -							
Regist	rar	APR 1	7 2006	RESSES .	for forth	and the second							
DHMH 17 Rev 1/20	001		200		ORIGINAL								

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Baltimore

2. Date of Death Month Day April 8, 2006

3. Time of Death

20:23

4c. County of Death

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		nar ylaria 1	Cert	ificate	of Dea	ith		yg.	Re	g. No.	200	6 1188
Physicia		Decedent's Name (First, Midd	le,Last)								Date of Deat	h	V	3. Time of Death
dical Exami	ner	Darnell Butler J	r.							Å	Month April 9, 20	Day 06	Year	4:46
**		4a. Facility Name (if not institution Sinai Hospital	on, give stree	et and number)				, Town, or L imore	ocation of	Death		4c. C	ounty of Death	
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. las	st birthday)		der 1 Year			. Date of Birt	h (MM/DE		nplace (State or Foreign
Director		212-02-9143	1X M	2 F	24		Yrs. Mor	ths Days	Hours	Min.	10-18-19	281		ntry) vland
		Usual Residence of Decedent							_l		10 10 1	701	LEAL	y Idila
<i>ж</i> апу		10a. State 10b. County		1	0c. City, T	Town or Lo	cation							10d. Inside City Limits
land f sho	ō	MD NA					Balt:	more						1 X Yes 2 No
Mary 28a-	Director	10e. Street and Number					10f. Z	ip Code			10	0g. Citizer	n of What Coun	try?
ith the Maryland 23a or 28a-f show any notified at once.	Ö	3302 Dorithan Roa	d					212					USA	
215-0036 be filed within 72 hours after death with the Maryland nital Hyggiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Never Married 1 Never M		Was Decedent E Armed Forces? Yes 2	ver in U.S No	13.	Was Dece If Yes, spe	dent of Hisp cify Cuban,	oanic Origir Mexican, F	n? (Specif Puerto Ric	fy Yes or No- an, etc.)	- 14	Race - Americ White, etc.	an Indian, Black,
after al", o		3 Wildowed 4 Di	vorced If Yes	, Give Year		1[Yes	2X No	specify:			Sp	pecify: B	lack
natur Xami	ed t	15. Decedent's Education (Spe				16a. Deced	dent's Usu	al Occupation	on (Give kir	nd of work	done	16b. Kin	d of Business/Ir	ndustry
n 72 h	Completed by	Elementary/Secondary (0-12		college (1-4 or 5+	•)				OT use retir	red)				
5-0036 led within 7 Hygiene. other than	mo	10					Hotwa		0.1.11.1	/=:			Racing	
15-	Be C	17. Father's Name (First, Middle						1	8.Mothers	Name (Fil	rst, Middle, N	valden Su	imame)	
2121 uld be fil Mental F marked c event, t	To B	Darnell Butler Sr 19a. Informant's Name/Relation		Print)		19b. Mai	ilina Addre	ss (Street	Ches and Numb	rie Ha	11 I Route Num	ber. City	or Town, State,	Zip Code)
MD 21 Id 2 should Ilth and Me In 27 is man	_	Cherie Harrison		,							, MD 21		,	,
		20a. Method of Disposition				ace of Dis	position (N	ame of cem			ate	_	cation - City or	Town, State
nor ant of nt: If		1 X Burial 2 Crematic		emoval from State	•	ematory or Zion C			(04-15-	06	T.an	sdowne, M	LD.
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	-					nd Address					odowie, i	
III II Per M		Am.	~	`			Wylie	Funera:	1 Home	638 N	. Gilmo	r St.	Balto, M	D 21217
Physician		23a. Part I. Enter the disease, o failure. List only one cause			ne death. I	Do not ente	er the mod	e of dying, s	such as car	diac or res	spiratory arre	est, shock	, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final diseas	0	shot Wound	of Tors	0								Death
<u> </u>		or condition resulting in death)		o (or as a conseq	uence of)	:								
	er	Sequentially list conditions, if any, leading to immediate	bbue to	o (or as a conseq	uence of)	:								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C											
red nsit	Exa	events resulting in death) Last		o (or as a conseq	uence of)	:								
760, icate be executed physician and the burial - transit	Medical	UNPENDED	dAM	ENDED										
760, icate be physici the buri	Med	IF FEMALE:	236	c. If yes, outcome	of pregna	ancv					-	23d. [Date of delivery	
687 certifica nding p	-	23b. Was decedent pregnant in past 12 months?		Live birth		2	Fetal dea	th 3	Ectopic p	pregnancy	,			yay Year
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	Physician		iknown 9	Pregnant at ti	me of dea	th 5	Other (S	pecify)						
the de	Phy	Part II. Other significant condi		Unknown	out not res	sulting in th	ne underly	ng cause d	iven in Part	ri	23e Did to	bacco usi	e contribute to t	he cause of death?
P.O.	ð			2-0.9 00 00-00		g	,	9 9						ably 4 Unknown
ds, equire een si	Completed										24a. Was	an	24b. Were aut	opsy findings available
law rahas b	nple										autop perfor	sy m <u>ed</u> ?		ompletion of cause of
of Vital Records, g Physician: The law require ther this certificate has been si neral director, page 2 should t	Co										1 🗸 Yes		1 ✔ Ye	s 2 No
of Vital Ing Physician: ther this certifineral director,	Be	25. Was case referred to medic examiner?	Hospita	al: 1 Innation	2 2 1	ER/Outpati	iont 3		of Death (0 Other ₄	Check only Nursing H	, _	Residence	- C Other	
Phys Phys er thi	^L	1 ✓ Yes 2 No 27. Manner of Death		i inpatient		28b. Time			y at Work?		d. Describe h			
Division can be or Attending its after death. The or Attending its after death. The or or or or or or or or or or or or or	Certification:	1 Natural 5 Per	ding estigation	8a. Date of Injury (Month Day,Yea Apr 9, 2006	ar)	4:16	o,u., y		es 2 🗸 N	Su	bject sho		occurred	
ivis or A after of Direct	tific	3 Suicide 6 Cou	ld not be	28e. Place of Inju	ry - At hor	me, farm, s	treet, facto	ry, office bu	uilding, etc.		or Town, S	tate)		al Route Number, City
Spital hours neral	Cer	4 Homicide	ermined	(Specify) stree	et					35	00 Lucille	Avenu	ue, Baltimor	e, MD
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deat	Medical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	aminer: On th	o the best of my ne basis of exami manner stated.										
F 3 F 8	Me	29b. Signature and title of certifi	er _		0		2	9c. License	number			29d. Da	te signed (Mor	nth, Day, Year)
		Caral H	ello	land	ter			O.C.N	И.E.			April	11, 2006	
27		30. Name and address of person Patricia Aronica-Polla	who comple				111	Penn Str	eet, Balt	timore, I	MD 2120	1		
St	ate	31. Date filed (Month, Day, Year,		32. Registrar's	Signature	e 🚜								
Regist			2006	Blocker	16	100	A.A.				<u>-</u>			

DHMH 17 Rev 1/2001 OCME 10/2003

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene | | | | Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 04 **Physician** 16:35 M Burkett Terry 2006 /Medical 4a. Facility Neme (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview City Baltimore Baltimore
er 1 Year | If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□ F 213-44-7591 Yrs. Maryland Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle rthen "naturel", or iteme 23a or 28a-f ehov Tre Medical Examiner must be notified at 1 ☐ Yes 2√2 No Middle River **Funeral Director** MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 21220 Road USA South Hawthorne 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) roofer/painter home improvements 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Burkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: If item 27 Is eny injury or other trau Sue Weimer/step daughter 2802 W. Woodwell Road Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature Licensee Ronald S. Wada marfille Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Myeloma
Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to limit ediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of): Examine physiclan and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records. P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No signed by the at Id be detached fo 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Hypoxemia, Itypo tension 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 2 No 1 Tes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■ Inpatient 2 □ EP/Outpatient 3 □ DOA 1 ☐ Yes 2 🔀 No this within 24 hours after death.
To the Funeral Director: After thi
controletely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19627 M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pat Kelly W.D. 4940 BALTIMORE MD 21724 EASTERN 31. Date filed (Month, Day, Year) 32. pgistrar's Signature State Registrar

			1 - For State Registrar	State of I	Marylar				ealth a	and Me	-	giene Reg. No:	106	WYTHIN A	891
	Physici	an	Decedent's Name (First, Middle, Las	t)						:	Date of Dea Month	ath Day	Year	3. Time	of Death
	/Media		RAYMOND J. CLIS								APRIL	-	2006	9:	30 A.M
)	Examir	ner	4a. Facility Name (If not institution, give		er)				Location o	of Death			unty of Dea	ith	
	p."		GOOD SAMARITAN H 5. Social Security Number 6. Se		Ago (la ven	last birthday)		ALTIN or 1 Year	IORE	24 Hrs 4	Data of Bird		/A	ab I (Or	
н	Funeral Director		1	X M 2□F		Yrs.	Months		Hours	Min.	3. Date of Birt (Month, Day	v, Year)	C	thplace (Sta	re or Foreign
			Usuel Residence of Decedent		84						9/19/1	927	MAI	RYLAND	
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside	City Limits
	Mar.	tor	MD BALTI	MORE		PARKVI	LLE							1 🗆 Y	es 2 XNo
	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "natural", or Items 23a or 28a-f ehow event, it a Madical Examinar must be notified at	ire	10e. Street and Number					p Code				10g. Citizer	of What C	ountry?	
		Funeral Director	8353 EDGEDALE RO	AD			2	1234				U.	SA		
	dea dea	Inel	11. Marital Status	12. Was Decede Armed Force		.S. 13. \	Was Dec	edent of Hi	spanic Orig	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)	14.	Race - Am Black, Whi	erican Indian	
98	or it	by FL	1 Never Married 2 Married	1 X Yes 2 [If Yes, Give			1 🗆 Yes		Specify:		,		ocific:		
21215-0036	"natural", o	D D	3	Year or Date	s: WWI]		da alla 11-		A:				\ \	WHITE	
1 5	n 72	To Be Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	kind of w	ual Occupa ork done d use retired,	lurina most	of working	7	16D. Kind	of Business	Vindustry	
12	within lene. than		Elementary/Secondary (0-12)	College (1-4d	or 5+)		NSTA					BALT	TMORE.	CO. G	OV!T.
	Hygin other ent,		12TH GRADE 17. Father's Name (First, Middle, Last)						18. Mothe	r's Name (First, Middle,				
<u>a</u>	thould be id Mental marked c matic eve		VINCENT L. CLIS	HAM					ADE	ELATD	E REED	ΣR			
Maryland	should ind Men marke umatic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	ng Addres	s (Street a			Route Numbe		own, State,	Zip Code)	
	and 2 Belth a n 27 to		JAMES A. FUGITT/S	ON-IN-LA	W	1304	BEL	LE ME	CADE F	RD.	FALLST	ON. MI	210	047	
Se	of He of He roth		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Domaval from Sta		Place of Dispo	sition (Na	me of other place		Da	1	20c. Locat	ion - City or	Town, State	
Ĕ	Peges ment of the		4 □ Donation 5 □ Other (Specify		LOF	RRAINE	PARK	CEM.	1	4/19/	2006	WOOI	OLAWN,	MD	
Baltimore,	permit. Peges 1 and 2 should Department of Heelth and Men Important: if item 27 is marke eny injury or other treumatic onge.		21. Signature of Funeral Service Licen	see		22	. Name a	nd Addres	s of Facility	THE	JOHNS	ON FUI	VERAL	HOME,	P.A.
<u> </u>	70 = 9 9					8	521	LOCH	RAVEN	V BLV	D. TO	WSON,	MD 2	21286	
} '	Physician /Medical Examiner		233 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ARTER I SSCLERSS Approximate Interval Between Onset and Death INSTANT Due to (or as a consequence of):										Between		
P.O. Box 68760,	Attending Physician: The law requires that the death certificate be executed crossib. robath. robath. the first certificate hes been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):												
	uires that the death certific signed by the attending p d be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)							23d	. Date of de Month	livery Day	Year	
rds, F	w requires that been signed should be det	þ	Part in Other significant continuous continuous to death but not resulting in the underlying cause given in Part i.									o the cause of robably 4			
Division of Vital Records,	I othe Hospital or Attending Physician: The law re thin 24 hours after death. To the Funersi Director: After this certificete hes be- completely filled in by the funeral director, page 2 sho	Be Completed								24a. Was an autopsy parformed? 1 Yes 2 No 1 Yes 2 No 1 No 24b. Were autopsy findings available prior to completion of cause of death?				gs available of cause of	
/ita	cian: ertific ector,		25. Was case referred to medical examiner?	26. Place of Death (Check only one)											
5	Shysi this o	မ	ILITES ZEFINO	Hospital: 1 Inpatient 2 ER/Outpatien							Home 5 ☐ Residence 6 ☐ Other (Specify)				
Ĕ	ing P	ü	27. Manner of Death 1 €Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)		28b. Time of Injury	Wo				28d. Describe how in		jury occurred		
<u>s</u>	ttend death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be						′es 2□N						
É	or A after Direction by	Certification;	4 ☐ Homicide determined	288. Place of						cation (Street and Number or Rural Route Number, ty or Town, State)					
	To the Hospital or Attent within 24 hours after death To the Funersi Director: completely filled in by the		29a. Certifier 1 Certifying Ph	/sician: To the be	st of my kno	wledge, death	Occurre	at the tim	e, date and	d place an	d due to the	ause(s) and	d manner as	s stated	
	• Ho 24 h • Fui letely	Medical	(Check only 2 Medical Examone)	iner: On the basis and manner	of examina	ition and/or inv	estigatio	n, in my op	inion, deat	h occurred	at the time, o	late and pla	ce, and due	e to the caus	e(s)
	To the within To the Comp	Me	29b. Signature and title of certifier) No			29	c. License	number			29d. Date si	gned (Mont	h, Day, Year)
) 1000 m	an Ul-	MA			D	2331	19		PARIL	-17	200	Ç
	421		30. Name and address of person who d	-	f death (Item	п 23а) (Туре,	,						. 3	11 /	6
	0,,		NATHAN ROSENO		760=	0X	ES	DRU	2	700	usen	M.	0 2	1207	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 7 2006		strar's Sign	iture								-2	

VOID

CERTIFICATE

06-11892

SEE

CERTIFICATE #

06-11011

			1 - For State Registrar	State of Marylan		artment o				iene eg. No.	11893		
			1. Decedent's Name (First, Middle, Last)						2. Date of Death	h Day Year	3. Time of Death		
	Physicia /Medic		George Campbell						March 30		3:00p M		
	Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Tow	n, or Location	of Death		4c. County of Death			
			Ivy Hall Nursing Ho	ome		Midd1	e Rive	r		Baltimore			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Ye Months Da		r 24 Hrs. Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)		
Н	Director		213-30-6217	76	Yrs.				March 8,				
	and		Usual Residence of Decedent 10a, State 10b, County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits		
	faryli sho	ō									1 ☐Yes 2 ☑ No		
	28a-	Funeral Director	MD Baltimore 10e. Street and Number	Mic	ldle Ri	Ver	10		10	0g. Citizen of What Cou	ntry?		
	with a or	ă									,		
	leath	era	1300 Windlass Drive	Was Decedent Ever in U	.S. 13. V	21220 Was Decedent		rigin? (Sp	ecify Yes or No-	USA 14. Race - Ameri	ican Indian,		
	fter d r Itan Ilner	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1	f Yes, specify (Cuban, Mexica	in, Puerto	ecify Yes or No- Rican, etc.)	Black, White	, etc.		
980	urs a	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	,	1 ☐ Yes 2 😾	No Specify	/ <u>:</u>		Specify: wh:	ito		
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show disal Examiliar must be nutified at	ted	15. Decedent's Educat (Specify only highest grade c	ion	16a. Deced	dent's Usual Oc	cupation	et of work	ina	16b. Kind of Business/Ir	ndustry		
21	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work do DO NDT use re	tired)	31 OF WORK	ing .		unk		
	filed wi Hygien sther th		unk unk		Farm	ner							
nd	be filt htal Hy ad oth	Be	17. Father's Name (First, Middle, Last)			unk	18. Moth	ner's Name	ə (First, Middle, N	Maiden Sumame)	unk		
altimore, Maryland	Mer	ဥ											
lar	2 sho		19a. Informant's Name/Relationship (Type)							, City or Town, State, Zi			
~	1 and Health am 27 other tr	1 1	Ivy Hall Nursing Ho		1300	Windla	ss Dri			ver, MD 212			
Ore	Pages 1 nent of H int: If Ita iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	oval from State	emetery, cren	sition (Name of natory or other	place)		Date 2	20c. Location - City or T	own, State		
Ē	men tant: jury		`4 □Donation 5 XOther (Specify) 1	n state/									
Bal	permit. Pag Department Important: I any injury o		21. Sign sture of Funeral Service Licensee Ronald S. Wa	Te 1 holes		. Name and Ad tate Δn		,	1 655 U	Baltimore	Ctwoot		
_	o □ ≥ a o		120111	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	Ba	altimor	e, MD	21201	. W CCO 1	Dallinore			
			23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death										
4	nysician	a a	immediate Cause (Final disease or condition 411000 ACCOND CONDUCTION WINCHON CONDUCTION										
	/Medical Examiner		resulting in death)	bue to (or as a conseq	uence of):	1 0	7200		200	7, =			
	Lammer	_	Sequentially list conditions, b. DADNOMY MILESTING										
	sit	Examiner	Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uenge or):	200	W.	1/3	(1)/h.	wm &	huare		
	and I-tran	хап	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	55/16	00/1	00	100010	sicienz &	Taraca		
8760,	death certificate be executed e attending physician and of for use as the burial-transit												
387	phys	edical	d						· · · · · · · · · · · · · · · · · · ·				
9 x	eath certific attending pl	/Me	IF FEMALE: 23c	If yes, outcome of pregna	ancv					23d. Date of deliv	(A.D.)		
Box	atten for u	Physician/M	in the past 12 months?	1☐Live birth 2☐Feta	I death 3	Ectopic pregna Other (specify				Month Month	Day Year		
o	the di y the sched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	outil oc	g Garlor (Speen)	/						
٦.	res that the de igned by the a be detached t	/Ph	Part II. Other significant conditions contri	outing to death but not res	ulting in the ur	nderlying cause	given in Part	1.	23e. Did tob	. Did tobacco use contribute to the cause of death?			
Vital Records,	law requires that as been signed b 2 should be deta	d by							1 Ye	1 Yes 2 □ No 3 □ Probably 4 □ Unknown			
Ö	w require been si should	Completed							24a. Was ar	24h Were aut	opsy findings available		
Rec	The lay ate has bage 2	шp								autopsy prior to completion of cause of death?			
<u></u>	n: Th									No 1□Yes	2 No		
₹	Physician: The law this certificate has b ral director, page 2 s	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	pital:	ED/O. I. I		0.1		h (Check only one		7.1		
ō	Phy ral d	. To	1 Impatent 2 Envolpatient 3 DOA 4 Environg Home 5 Hesidence 6 Other (Specify)										
	ding f h. After funer	tlor	27. Manner of D ¹ ath 1 Thatural 5 Pending investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28c. Injury at Work? 1 Yes 2 No 28b. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred										
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Οį	i te	erti	4 Homicide	building, etc. (Specif	(y)				City or Town	n, State)			
	To the Hospital or At within 24 hours after or To the Funaral Direct completely filled in by		29a. Certifier 1 Certifying Physic	ian: To the best of my kno	wledge, death	n occurred at th	e time, date a	ind place,	and due to the ca	ause(s) and manner as	stated.		
	e Ho e Fu	edical	(Check only one) 2 Medical Examine	 On the basis of examina and manner stated. 	tion and/or inv	vestigation, in n	ny opinion, de	ath occur	red at the time, da	ate and place, and due	to the cause(s)		
	withir To th	Me	29b. Signature and title of certifier	1/0	,	29c. Lic	ense number		29	9d. Date signed (Month,	Day, Year)		
)			SALY F	VOIV-	11	1 7	38	03.	3	4/6/0	6		
			30. Name and ad it is of person to com	pleted cause of death (119	23a) (Type,	Print	11	10	OA	1 -			
			L. Hair	1615.	1/1/1	1.aug	1100	10	tnu	in [ii)	21044		
	Sta	te	31. Date filed (Month, Day, Year)	62. Registrar's Signa	ture	1							
	Registr	air	APR 1 7 2006	The 190 Sa	and the same								

America Type or Print in Black indelible lak. Ensure All Copies Are Legible.

State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 200 10 Craddock Jerry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Genera saltimore Ian If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) 8 **Funeral** Days Year) Hours XXM 2 F Yrs. 240-22-8612 86 03 Director 03 20 NC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Madical Examiner must be notified at XXYes 2□No Directo MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a 3914 Edgewood 21215 Road U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ Specify Black 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene. is marked other then "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Locheed Martin Elementary/Secondary (0-12) College (1-4or 5+) Maintanance 6th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth eny liquy or other traumatic event 9008. Be Fred Craddock <u>Velma Lyles</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Craddock-Wife 3914 Edgewood Road, Baltimore, Md Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State

□ Donation 5 □ Other (Specify) King Memorial Park 4/16/06 Randallstown, Md OnFuneral Service Lio 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 11/40 cardia Physician /Medical Due to (or as a consequence of) Examiner 81 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an med? certificate 2 No 1 Yes 1 🗆 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient မှ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 1 2 Natural 28b. Time of Injury 28c. Injury at Work? Certification; 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 3 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 12 Cartifying Physician: To the hest of my knowledge death considered at the time, date and place and due to the date of place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pranimi 32. Registrar's Signature 31. Date filed (Month, D

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2006/2:48 AM Beulah E. Duckworth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Square Hospita oseo More Franklin a rear If Under 24 Hrs. 8. Date of Birth (Month Pay 1987) But Occ. 31 1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 TF 214 07 3652 88 Director Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f ehov The Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 106 S. Stuart Street 21221 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Himore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Merchandiser Utility Company 12 ages 1 and 2 should be filed on of Health and Mental Hygie t: If Item 27 is marked other? y or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Clark Gertrude Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lois Henre (Daughter) 126 E. Padonia Rd. Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages Depertment of Important: If It any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pleasant Grove Methodist 4/18/2006 Cumberland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature, of Funeral Service Licensee 22. Name and Address of Eacility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ε Immediate Cause (Final disease or condition resulting in death) MyoCardi **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be d Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

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State

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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			1- For State of Maryland / Departs Registrer Certifi	ment of Health and M licate of Death		4000	1896				
			Decedent's Name (First, Middle, Last)	Totalo or Dodari	Reg. 2. Date of Death		3. Time of Death				
П	Physici /Medio		EARL DAVIDSON		Apr.	Day Year 7 2006	202 IM				
	Examir		4a. Facility Name (If not institution, give street and number)	c. City, Town, or Location of Death		4c. County of Death	· · · · · · · · · · · · · · · · · · ·				
			7846 Creek Shore WAY	PASAdeNA		AA					
	Funeral Director		534-86-7239 1XM 2 F 42 Yrs. M	Onths Days Hours Min.	8. Date of Birth (Month, Day Ye Sept. 06	9. Birthpla Count	ace (State or Foreign M)				
	pur M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on		10	d. Inside City Limits				
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itams 23e or 28a-f ahow any Injury or other traumatic avent, the Madical Examiner must be notified at once.		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ame and Address of Facility	Stallings	Funeral Ho					
				111 Mountain Roa			Approximate				
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ã	ath cer trendir or use	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ect			23d. Date of delivery Month Day Year					
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	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certifice completely filled in by the funeral director, to	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investigant manner stated.	curred at the time, date and place, gation, in my opinion, death occurr	and due to the caus	e(s) and manner as sta	ted. he cause(s)				
	To th withir To th comp	Me	29b. Signature and title of certifier Deputy	29c. License number		Date signed (Month, D					
			Million D. posmo	D 06054	4	4/17/6					
	3+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	D 06054	- IÉA	21035					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	de	,						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2006 16, MARY LOU DOYLE Apri1 3:00 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7828 St. Bridget Lane Baltimore County Dunda1k

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Yrs. Director June 5, 1933 214-30-7300 Maryland Usuat Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23s or 28e-f show any Injury or other traumatic event, Its Medical Examinating manification once. 1 ☐ Yes 2 ▼ No Funeral Director Maryland Baltimore County Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 7828 St. Bridget Lane USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No White Specify: Be Completed by 3 NWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 12 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Louis Gill, Sr. Margaret M. Brandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Earp (Pers. Rep.) 9 Washington Street, Timonium, Maryland 21093 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 4/19/2006 Oak Lawn Cemetery Baltimore, Maryland 21. Signature Funeral Service Language 22. Name and Address of Facility Mitchell-Wiedefeld Funeral nome, 1000 Mitchell-Wiedefeld Funeral nome, 21212 Approximate Interval Between Onset and Death Martin D. auson Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cours /Medical Due to (or as a confequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Eulong To the Hospital or Attending Physician: The law requires that the death certificate be executed be detached for use as the burial-transit and Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐triknown 1 Tyes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed 1 🗌 Yes 2 1 No Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Medical Certification; To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manny of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 - Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Rough attanasia MD D-2-897 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Attenasio, M.D., 9114 Philadelphia Road, Baltimore, MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Davage Joseph 04 12 2006 5:30a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crownsville Heritage Harbour Health If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 2 🗆 F Yrs 84 Director 219-03-6895 06 18 21 MD Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other treumatic avant, the Madical Examinar must be notified at Director 1 ☐ Yes XXNo Crownsville Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21032 1262 Sheridan Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". And any injury or other traumant. Y Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) U.S. Postal Service 3yrs Postal Clerk 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anna E. Banks ဥ John Davage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1262 Sheridan Road, Crownsville, Md 21032 Lelia Davage-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/18/06 Elkridge, Md Donation 5 Other (Specify) Meadow Ridge 21. Signature of Puneral Service Lisen Name and Address of Eachlity arch F/H West 300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence/of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician end for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 4 Pregnant at time of death P.O. I the 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ate has been signi page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? (es 200 N certificate 1 ☐ Yes o the Hospitel or Attending Physician: After this certification, I Be 25. Was case referred to medical examiner? 26. Place of Death Check only on 1 ☐ Yes 2 No Other: Grant Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours at To the Funeral D 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9065 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State 2006 Registrar

			1 - State of Maryland / Department of Health and Maryland / Department of Health And Maryland / Department of Health And Maryland / Department /	_	giene Reg. No.	006	11899
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Baltir	permit. Pages Depertment of important: If it eny injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility TH 8521 LOCH RAVEN BL	E JOHNS		ERAL H	
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires the within 24 hours elter death within 24 hours elter death of The Funeral Director: Alter this certificate has been signed completely tilled in by the funeral director, page 2 should be de	Certification; To B	Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Ho 27. Manner of Jeach 1 Natural 5 Pending (Month, Day Year) 28a. Late of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	ome 5 ☐ Residence 128d. Describe he	ence 6 🗆 O)
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i	Sta Registr		IKE MBONU, MD LITTLE PATUXENT PARKWAY COLUMBIA, MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature	21044			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Charlene Evalyn Davy 2006 /Medical March 11 7:10 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 414 Kensington Road Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 8, 1946 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 💢 F California 59 Director 555-70-4768 Usual Residence of Decedent the Marylend 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at Director 1√ Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code USA or items 23a 21229 414 Kensington Road Completed by Funeral iit. Pages 1 and 2 should be filed within 72 hours after death cirnent of Health and Mental Hygiene.
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injury or other traumatic event, the Medical Examination 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Justus Axel Ollson Dorothea Luetta Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John G. Davy/spouse 414 Kensington Road Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Ronald S permit.
Deporter Importer any mju 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street icensee Wade Dip error Baltimore, MĎ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) 3 30004 Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month signed by the at d be detached fo 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 Mo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No s certificate has b irrector, page 2 s 24a. Was an 1 Yes 2 No or Attending Physician: 24 hours after death.

Funeref Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \[\] Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) suchers un 022119 march 14, 200 x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 4/1 040 FREDERBUE PAMEAN BARCHESS BACTEMBRE MARKETUD LIZAS 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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Baltimore, Mai	it. Pages 1 and 2 rtment of Health a rtent: if item 27 is njury or other trai		19a. Informant's Name/Relationship (T) Southern Maryland 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 ② Other (Specify) 21. Signature of Funeral Security Licenses	Hospital 20b. For State in state	7503 Place of Dispo emetery, crer	Surra esition (Nam matory or o	atts ne of ther place	Road		ton, MD	City or Town, State 20735 Oc. Location - City)
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				ler hun 117	23a) (Type, I	Print)			Fort		lington.		٠٤
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 250 AM Jarch Justeen Etz /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Heaith and Behab Harford BO AiR 8. Date of Birth (Month, Day, Y June 23, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 □ M 2 🛱 F Hours Yrs. 73 1932 218-28-0641 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10h Counts 10d. Inside City Limits 1 ☐ Yes 2√2 No Director MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3714 Woodale Road 21001 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No 3 Widowed 4 Divorced Specify: white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk seamstress factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kermit Horton 2 Fannie Bauguess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Palmatto Park Drive #B3 Charleston, SC 29407 Thomas Rhodes/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ☑Other (Specify) in state 21. Si statura of Funeral Service Licensee Ronald S. W. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 7000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Gause (Final disease or condition resulting in death) -0/0n Cancer Due to (or as a consequence of): Sequentially list conditions, if any, is along to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of)

Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detact

1335CI

Certification: To Be Completed by Physician/Medical Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23a or 28s-1 show eny injury or other traumatic event. If a Medical Examinal must be notified at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3 ☐ Ector	oic pregnancy or (specify)	<u></u>	23d. Date of delivery Month Day Year
Part II. Other significant conditions con	tributing to death but not res	sulting in the underly	ing cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
				24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No	24b. Were autopsy findings available prior to completion of cause of death? 1 \sum Yes 2 \sum No
25. Was case referred to medical examiner?				Death Check only one	
1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient 2	ER/Outpatient 3[DOA Other: 4-X Nursin	g Home 5 🗆 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how infu	ry occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fa	actory, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
29a. Certifier 1 ertifying Phys (Check only one) 2 Medical Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occu ation and/or investig	rred at the time. date and blatton, in my opinion, death o	ace, and due to the cause s ccurred at the time, date an	and minner all states d place, and due to the cause(s)
29b. Signature and title of certifier	D		29c. License number 03465 2	29d. Da	ite signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

		1	- State Amend Item	State of Marylar 23a per dr.,	354 Jul	tificate	of Health and e of Death			U6 119U3
	Dhucinic		1. Decedent's Name (First, Middle, Las					2. Date of Dea	Day	Year 3. Time of Death Q · O P M
	Physicia /Medic	al	MARY MAXINE E			41 07	T	04.07		q:00 P M
	Examin	er	4a. Facility Name (If not institution, give NORTH ARUNDEL	HOSPITAL		GLE			ANN	ARUNDEL
	Funeral Director		5. Social Security Number 6. S 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (<i>In yr</i> s. ☐ M 2020 F 15	last birthday) Yrs.	If Under Months	1 Year If Under 24 Hrs Days Hours Min		1931	9. Birthptace (State or Foreign Country)
L	D		Usuat Residence of Decedent							10d. Inside City Limits
	anylar ehow	_	10a. State 10b. County		ity, Town or Lo EN Bl		:			1 ☐ Yes 2 ☑ No
	he M	Director	MD ANN ARI	UNDEL GI	EN BO	10f. Zip			10a. Citizen a	f What Country?
	with t	ā	1355 FULNACE B	RANCH RD		101. Elp	21061			LSA
	deeth with the Maryland me 23a or 28e-f ehow	Funerai	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Deced	dent of Hispanic Origin? (Specify Yes or No-		ace - American Indian, lack, White, etc.
9	or ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 N o If Yes, Give	1	1 ☐ Yes :		to ritoan, otc.)	Spec	
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:	162 Doco	doot's Heus	al Occupation			Business/Industry
7	n 72 l	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give		rk done during most of we	orking	100. 14114 51	boomboo maasii y
212	iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	W	AMRES	38		FOOD_	SERVICE
2	e filecal Hyg	BeC	17. Father's Name (First, Middle, Last,					me (First, Middle,		
Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Marylan and Mental hygiens and Mental hygiens is marked other then "naturet, or iteme 23a or 28e-f show is marked other then "naturet, or iteme 23a or 28e-f show is marked other the Marsical Examinar result be notified at	To E	CLARENCE ELKIN				MARY 1		COPEN	
Jar	ges 1 end 2 should nt of Health and Men if Item 27 is marke or other treumatic		19a. Informant's Name/Relationship (1 000		(Street and Number or F		An al	n, State, Zip Code)
	permit. Pages 1 end 2 Department of Health a Importent: If item 27 it any in ury or other tre		9ANDRA DORTON E	ELKINS 20b.	Place of Dispo	osition (Nan	ne of	BALTO. N	20c. Locatio	n - City or Town, State
ō	Pages nent of nut: If it ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cre EEUMO	•		11-06	BALIO.	MD
Baltimore,	artme orten injur	1	21. Sign ture of Funeral Service Licer		2	2. Name an	nd Address of Facility C. GREEUE F			.00
ä	permit. Departn Import		Vanon C		VA 51	iughn 51 BAI	LO. NATU PIK	E. BAUD.	MO 21	229
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final	plications that caused the dea one cause on each line.	th. Do not en		le of dying, such as cardinoiration Pri		rest,	Approximate Interval Between Onset and Death
П	/Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):					[] [] [] [] [] [] [] [] [] []
П	Examiner		Sequentially list conditions,	1 Al 241	SIME	2Rs	DEMI	ENTIA		
	be sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence ot):					
•	xecut and	xan	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					
8760,	icate be executed physicien and s the burial-transit	dicai E		d.						
9	tificate ng phy as the	ledic								
Вох	death certific e attending p od for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	□Ectopic p				Date of delivery Month Day Year
	e dea the att	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (s)	pecify)			
P.0.	requires that the de the signed by the a hould be deteched t	by Physician/Me	Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying o	cause given in Part I.	23e. Did to	obacco use c	ontribute to the cause of death?
ds,	w requires to been signer should be contact to the should be contact to	d b						101	res 200 No	3 Probably 4 Unknown
co	> 40	Completed						24a. Was		b. Were autopsy findings available prior to completion of cause of
Re	The law ete has b paga 2 si	mo						autop perfo	med? S ☑ No	death? 1 ☐ Yes > No
ital		Bec	25. Was case referred to medical examiner?					eath Check only o		
> =	hys I di	10	1 ☐ Yes 2 No		☐ ER/Outpatie			Home 5 Resid		
ū			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe I	now injury oc	currea
0	ing P	<u>6</u>	1 Natural 5 ☐ Pending			IAI	1 103 2 100			
<u>isi</u>	ittending P death. ctor: After t / the funera	ication:	2 Accident investigation 3 Suicide 6 Could not in	n Place of Injury - At	home, farm, s	treet, factor	v. office	28f. Location (S	Street and Nu	imber or Rural Route Number,
Division of Vital Records,	it or Attending Patter death. I Director: After the in by the funera	ertification	2 Accident investigation	n Place of Injury - At	home, farm, si	treet, factor	y, office	28f. Location (City or Tox	Street and Nu wn, State)	imber or Rural Route Number,
Division	Hospital or Attending 4 hours after death. Funerel Director: After lely filled in by the fune	licai Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined 29a. Certifier TX Certifying P (Check only 2 Medical Exa	28e. Place of Injury - At building, etc. (Spectrum)	cify) nowledge, dea	ith occurred	at the time, date and pla	City or Tox	wn, State) cause(s) and	manner as stated.
Division	Hospital or Attending 4 hours after death. Funerel Director: After lely filled in by the fune	Medical Certification:	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined	28e. Place of Injury - At building, etc. (Spectrostics)	cify) nowledge, dea	nth occurred	d at the time, date and pla n, in my opinion, death oc lc. License number	ce, and due to the curred at the time,	cause(s) and date and place 29d. Date sig	manner as stated. ce, and due to the cause(s) gned (Month, Dey, Year)
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	edicai	2 Accident investigation 3 Suicide 6 Could not I 4 Homicide determined 29a. Certifier TX Certifying P (Check only one)	28e. Place of Injury - At building, etc. (Spectrum)	cify) nowledge, dea	nth occurred	d at the time, date and pla n, in my opinion, death oc lc. License number	ce, and due to the curred at the time,	cause(s) and date and place 29d. Date sig	manner as stated. ce, and due to the cause(s) gned (Month, Dey, Year)
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Division	Hospital or Attending 4 hours after death. Funerel Director: After lely filled in by the fune	edicai	2 Accident 3 Suicide 6 Could not I 4 Homicide 6 Certifying P (Check only one) 29b. Signature and title of certifier	28e. Place of Injury - At building, etc. (Specials: To the best of my kiminer: On the basis of examiand manner stated.	em 23a) (Type	nth occurred	d at the time, date and pla n, in my opinion, death oc lc. License number	ce, and due to the curred at the time,	cause(s) and date and place 29d. Date sig	manner as stated. ce, and due to the cause(s)

DHMH 17 Rev 1/2001

Mary M EIKINS

			1 → For State Ragistrar	State of M	aryland		artmen rtificate			and M		giene Reg. No:	6 11904
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last,			E	rVIN		Location o	of Death	2. Date of De Month April	Day \	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sec. 218-58-3815	AM OFF	Centro e (In yrs. las 52			4im		24 Hrs.	8. Date of Birl (Month, Da Sept.	Baltim	. /
	e Maryland 3a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltim	ore	10c. City, 7	Town or Lo	cation		Es	ssex			10d. Inside City Limits 1 ☐ Yes 2 ☒ No
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iteme 23e or 28e-f ehow eny injury or other treumatic event, the Mardical Examinar must be invitted at once.	by Funeral Dire	1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give			10f. Zip Was Deced I Yes, spec	ent of Hi	21221 spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)	United 14. Race- Black, Specify:	States American Indian, White, etc.
21215-0036	ed within 72 hour glene. er than "natural"	Completed b	3 Widowed 4	Year or Dates: cation a completed) College (1-4or 5		I6a. Deced (Give life. L	lent's Usua	l Occupa k done d e retired,	ition luring most	of working	g	16b. Kind of Busin	White Ress/Industry Electric Corp
Maryland	should be file nd Mental Hy marked oth umatic event	To Be (17. Father's Name (First, Middle, Last) William A. Ervin 19a. Informant's Name/Relationship (Ty)	oe, Print)					18. Mother	ula :	L. Cas	Maiden Sumame) SSell or, City or Town, Sta	
altimore, Ma	ages 1 and 2 nt of Health a n: If Itam 27 is or other tree		Martha Sue Cochra: 20a. Method of Disposition 1 ☐ Burial 22 Cremation 3 ☐ Re		20b. Płac	210: e of Dispos etery, crem	l Sil	Ver e of her place	Lane	Ess	ex, Mar	ryland 2	ty or Town, State
B altin	permit. P Departme Important eny injury		4 Donation 9 Other (Specify) 21. Signature of theral Solvice in any	The	M	22 D1	Name and uda-Ri 7922 T	Addres uck Wise	Ave.	al Ho	ome of	Dundalk, Marvland	
	Physician /Medical		23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Acute Due to (or as	Renal	Fail	ſ	ol dying	, such as c	cardiac or	respiratory ari	rest,	Approximate Interval Between Onset and Death 2 weeks
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	а солѕециел								2+ weeks
.O. Box 68	law requires that the death certifica as been signed by the ettending ph 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live birth 1 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal de	ath 3 □I	Ectopic pre Other <i>(spe</i>	gnancy cify)				23d. Date of Month	f delivery Day Year
Records, P	w requires that been signed I should be det	eted by P	Part II. Other significant conditions cont Liver failure sp	ributing to death bu	it not resultin	g in the un	derlying car	use giver	n in Part I.				te to the cause of death?
<u> </u>	iician: The law certificate has b rector, page 2 s	0	25. Was case referred to medical			_			26 Place o	of Death /	24a. Was a autops perform 1 Yes 2	med deat 2. No 1 □	
TO UC	fing Phys	atlon; To B	27. Manner of Death 1 Valural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day		Outpatient D. Time of Injury		Other c. Injury : Work?	4 🗆 Nurs	sing Home	5 🗆 Reside	ence 6 Other (Specify)
		al Certification;	3 Suicide 4 Homicide Could not be determined	28e. Place of Injubuilding, etc.	(Specify)	(an death	resurred at	the House	Hata and a	alsea And	City or Town	n, State)	r Rural Route Number,
:	To the Ho within 24 I To the Fu completely	Medical	(Check only 2 Medical Examine 29b. Signature and title of certifier	er: On the basis of and manner stat	examination	and/or inve	29c. I	License	nion, death	occurred	at the time, da	ate and place, and 9d. Date signed (M April 9,	due to the cause(s) fonth, Day, Year)
le	1	e	30. Name and address of person who com Jeffrey Highfill 31. Date filed (Month, Day, Year) APR 1 7 20	32. Pegistrai	ath (Item 23a 140 Ed	a) (Type, Pasteri					re, MC	21224	

			1 - For State Registrar	State of Marylar		artment of He rtificate of D		- '	giene 006	11905
	0		Decedent's Name (First, Middle, La	st)				2. Date of Dea		3. Time of Death
	Physici		George	Fisher				And I	15 2 ot	1 31 11 AM
	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or L	ocation of Death	P	4c. County of De	2
1	Examir	er				Rosedale	0		Baltimo	ro
	Francis		Franklin Woods No. 5. Social Security Number 6. S		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h 9. E	hirthplace (State or Foreign Country)
	Funeral Director			M 2□F 80	Yrs.	Months Days	Hours Min.	(Month, Da) 10/24/	1925 Ma	ryland
			Usual Residence of Decedent					10/22/		
	ylancy 10.W		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mar.	ģ	Maryland Baltimo	re Es	sex					1 ☐ Yes 2 XNo
	r 282	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	h wit	Funeral Director	820 Martin Road			21221			U. S. A.	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hist f Yes, specify Cuban,	panic Origin? (Spe	ecify Yes or No-	14. Race - Ar Black, W	nerican Indian,
9	or Ite	교	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give	ì	- 37	Specify:	riicari, oto.,	Specify:	inte, etc.
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examinat must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates: WW			Opochy.		Зреслу.	White
5-0	72 h natu	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	(Give	dent's Usual Occupati kind of work done du	ion iring most of worki	ing	16b. Kind of Busine	ss/Industry
21	ithin Ban Man	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)				
N	ed w ygier yertt	Ö	9		Longs	horeman	10 Maria da Maria	/Fine 14:44	Marine T	erminai
힏	tal H d oth	Be	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
χ	2 should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural, or I raumatic event, the Medical Exami	ို		er, SR.			Anna Be			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print)					er, City or Town, State	o, Zip Code)
<u>~</u>	and lealth m 27 her t		Jeannie O'Connor			North Marl		e Esse	x, Marylar 20c. Location - City	
9	Pes 1		20a. Method of Disposition 1 Durial 2 Cremation 3		cemetery, crei	natory or other place)			20c. Location - City	or rown, state
Ë	ment:		`4 □ Donation 5 □ Other (Speci			Cemetery		06	Baltimore	, Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tra <u>once</u> .		21. Signature of Funeral Service Lice	nsee // /	Br	2. Name and Address UZdZinski	Funeral	Home P.	A	
ш	₫ O ⊑ @ ol		Michael C. g.	efficial Sr.	14	<u>107 Old Ea</u>	stern Av	enue E	ssex, Mary	land 21221
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not ent	er the mode of dying,	such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. Chronic	Kesp	ratory	Fail	4re		
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of:					
	CXAHIIHEI		Sequentially list conditions, if any, leading to immediate	b. SICCP	apne	Z				
	D 15	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or all a conse	quence of):					
	and and trans	Саш	that initiated events resulting in death) Last	c. Due to (or as a conse	augano of):					-
760,	ate be executed hysician and the burial-transit		roodking in doubly addit	Due to (or as a conse	quence or).					
_	hysic the b	dical	•	d						
39 >	death certificat e attending phy od for use as th	Physician/Med	IF FEMALE:	00. 1/			-			
Вох	ath or tlend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	tal death 3	Ectopic pregnancy			23d. Date of o Month	delivery Day Year
0	0 0 2	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5L	Other (specify)				
<u>Б</u>	requires that the desence signed by the a		Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause giver	n in Part I	23e. Did to	obacco use contribute	to the cause of death?
S,	signe l be d	by	Consection ho	and Ailing	And	11	ronic	101	_	Probably 4 Unknown
0.0	req eer hou	sted	Congestive rice	of John C	1110	1.1	1.01116			
Records,	a s	Completed	Kidney distas	e, Diapetes	mel	117US		24a. Was autop	an 24b. Were prior med? death	autopsy findings available o completion of cause of
=	Th ate pag	Cor	/					1 ☐ Yes	2 4 √0 1 1 1 Y	es 2 No
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Deatl			
)	S D	L C	1 ☐ Yes 2 ☐ No	1 Inpatient 2L	ER/Outpatie		4 GHRursing no		dence 6 Other (S	pecify)
Ē	ding Phys	on:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Work?	es 2 No	200. Describe i	low injury occurred	
Sic	Attending or death. ector: Atterby the fune	cat	2 Accident investigation 3 Suicide 6 Could not to		homo form at		62 5 140	29f Location (Street and Number or	Rural Route Number
Division	or Al	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, iami, si sify)	eet, factory, office		City or Tov		riorar riodie rioriber,
	To the Hospital or Attending Ph within E4 hours after death. To the Funeral Director: After th completely filled in by the funeral	2	29a. Certifier 1 Certifying P	hysicien: To the best of my kr	nowledge does	h occurred at the time	date and stoop	and due to the	rause(s) and manner	as stated
	Hos 24 ho Fun stely (edical	(Check only 2 Medicel Exa	miner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my opi	inion, death occuri	red at the time,	date and place, and o	lue to the cause(s)
	thin S	Me	29b. Signature and title of certifier	and mainter states.		29c. License	number		29d. Date signed (Mo	onth, Day, Year)
	Vit To		17- 11	1	i	NHC	-76%		Anc 1 17	200/
	11		30 Name and address of parent	completed cause of death (Ite	om 23a\ (Tupo	Print)	100	/	79111	2 UVB
	00		30. Name and address of person who	21D9105 Fm.	Dia S	Harra An	Ste. 312	Br. 15:	none MI	7/2/17
		ate	31. Date filed (Month, Rap Kear)	2005 32. Retristrar's Sign	nature	Contraction .	210, 210)	Day 111	1146/2-11	1911
	Regist		ALK T	CUUU MARINE	200	4				

			1 - For State Registrar	State of N	/larylar		artmen					giene Reg. No.	06	9	05
	Physici	an	1. Decedent's Name (First, Middle, Las	•					_	1	2. Date of De		Year	3. Time o	_
	/Medic	al	Roberta May Fra 4a. Facility Name (If not institution, give		0 0		4b. City,	Town, or	Location e	of Death	19011	4c Count	ty of Death	7 7 7 7	5 AM
	Examin	er	Franklin Square	Hospita	(er	Her	P	105	eda	le		Ba	Ltin	nore	
	Funeral Director		5. Social Security Number 6. So 1	x	Age (In yrs. 89	last birthday, Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bird (Month, Da lay 18,	y. 1916	9. Birth	hplace (State of unital) 'y Land	or Foreign
	D.		Usual Residence of Decedent			ty, Town or L							1	10d. Inside C	itu t imite
	Marylend	ō	10a. State 10b. County MD Baltimo	re	100.01	Dunda									2 No
	th the Maryler or 28e-f ehow e notified at	by Funeral Director	10e. Street and Number			Dange	10f. Zip	Code				10g. Citizen of	What Cou	untry?	
\gtrsim	death with the me 23a or 28e	rai	8353 Kavanaugh Ro		. =			212		-1-0 (0	* VN-		SA	door ladios	
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Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: '\'				Othe			(Check only o				
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	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the besiner: On the basis and manner	of examina										s)
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			30. Name and address of person who	A Nmy	MI)	9000	rank	ins	guar	eDr	ive, b	altimor	e, M	D 212	237
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ature	asset !		¥						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#18, peristate of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Clarence Gunter Jr 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death, 4b. City, Town, or Location of Death Examiner GEN BURNIE If Under 1 Year If Under 24 Hrs. BALTIMORE WASHINGTON Medical ANNE Lenter RUNGE 8. Date of Birth (Month, Day, Year) Sept 20, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 WV **Funeral** Days XXM 2□F Hours Min. Yrs. Sept Director 234-46-0051 75 Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Anne Arundel Co Glen Burnie 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 1711 Saunders Way 21061 USA Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married XX Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Cook US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ursula Ida Lobe Clarence Gunter, Sr Oreta Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is eny injury or other tra QDCs. Ursula I. Gunter Wife 1711 Saunders Way, Glen Burnie, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownaville Vets Cem 4-21-06 Crownsville, MD 4 □Donation 5 □ Other (Specify) 21. Sign fly le Funeral Corrice Licenses Fink Funeral Home, P.A. FIN MO1148 Gregory 426 Crain Hwy SW, Glen Burnie, MD 23a. Part 1. Enter the disea shock, or heart failure ase, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner austo-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 moo 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatb? Division of Vital Records. þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. neral Director: A filled in by the fa 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 | Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) ltr. DANG

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

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32. Begistrar's Signature

DHMH 17 Rev 1/2001

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,			1 - For State Registrar	State of M	laryland / De	partment of ertificate of				ene	6	11909
	Physici		1. Decedent's Name (First, Middle, La	SIGIES				A	2. Date of Death Month	Daylh	Year	3. Time of Death 3/20 A - M
	/Medio Examin		4a. Facility Name (If not institution, giv)	4b. City, Town,	or Location of		Move?	4c. County of Balt		1
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. last birthd	ay) If Under 1 Yea Months Day	r If Under	24 Hrs.	8. Date of Birth (Month, Day, Y Aug. 24, 1	(ear)		lace (State or Foreign
	arylend show	J.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location					11	0d. Inside City Limits
	or 28a-f	Director	MD Baltim 10e. Street and Number	ore	Reis	sterstown 10f. Zip Code			100	g. Citizen of W	hat Coun	
036	permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, the Medical Executes must be notified at once.	by Funeral	23 Wolf Ave. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?	21 3. Was Decedent of If Yes, specify Cu	ban, Mexicar	n, Puerto R	ify Yes or No- ican, etc.)	14. Race	, White, e	an Indian, etc.
Baltimore, Maryland 21215-0036	d within 72 ho giene. or than "natur i the Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or	(G	cedent's Usual Occive kind of work don b. DO NOT use retir	e during mos ed)	t of workin	g16	Own H		dustry
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			For State Registrar	State of Ma	aryland	d / Depa	artment o		d Mental Hy		06	4 may 9
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	Funeral Director			Sex 7. Ag 1□M 2\XF 92		ast birthday) Yrs.	If Under 1 Y	ear If Under 24	Hrs. 8. Date of Bir (Month, Da Oct 11	th 19, Year) 1911	9. Birth Con Md	nplace (State or Foreign untry)
	e-f ehow	ctor	10a. State 10b. County Howard	d	10c. City	Town or Lo Co1	umbia					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	th with th	Funeral Director	10e. Street and Number 6336 Cedar Lane				10f. Zip Coo 2104			10g. Citize USA	n of What Co	untry?
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DHMH 17 Rev 1/2001

			1 - For State Registrer	State of M	laryland		artmen rtificat				, ,	ene g. No.		110	Page 10
			1. Decedent's Name (First, Middle, Last								Date of Death	1		3. Time of	f Death
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	Examir		4a. Facility Name (If not institution, give	street and number))		4b. City,	Town, or	Location o	of Death	(4c. Count	y of Death		
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	Funeral		Social Security Number 6. Security Number		ge (In yrs. las	* * * * * * * * * * * * * * * * * * * *	If Under Months	1 Year Days	If Under :	24 Hrs. 8 Min.	. Date of Birth (Month, Day,			lace (State o	or Foreign
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ဗ္ဗ	of', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2∏ No	Specify:			Speci	<i>ћ</i> : Ъ1	ack	
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Maryland 21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department if Item 27 is marked other than "naturer", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Madical Examinar must be notified at once.	ပ္													
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0	Pages nent of h int: if Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ P	emoval from State		ce of Dispo netery, cren	natory or o	ne or ther place)	Dat	9 2	Oc. Location	- City or To	wn, State	
Baltimore,	t. Pa tmen tant: jury		4 □ Donation 5 ☑ Other (Specify)	in stat	:e				į						
Bal	permit. Departr Imports any Inju		21. Si natur of Funeral Service Licens Ronal CS	ala Dire	ector	St.	. Name an	d Address	s of Facility My BC	bard. 6	55 W. I	Baltim	ore S	treet	
	TOTEG		1 mon 1	we								_			
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	e cause on each li	ine.					,	7			Approximate Interval Bet Onset and D	ween
}	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)		96	por	un	Na	20%	stre	Shu	CIC		Chiser and c	204(11
T.	Examiner		1	Due to (or as	a consequer	nce of):	-	, ,	1	- 1	Shu				
		-	Sequentially list conditions,	Due to (or as	117	Vijoc	Cler	5 0	000	nas					
	nsit	<u>u</u>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 10 (61 43	a consequer	100,017.									
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):					-				
8760	icate be executed physician and s the burial-transit	dical													
89	ifficat g phy as the	edic													
Box	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome								23d. Da	ite of delive	rv	
m ·	death d for	Ca	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at			Ectopic pre Other (spe						onth		/ear
o.	law requires that the death certific as been signed by the attending p ? Should be detached for use as	Physician/Me	9 Unknown	9□ Unknown											
ś	as tha	by P	Part II. Other significant conditions con	tributing to death b	ut not resultir	ng in the ur	derlying ca	luse give	n in Part I.		23e. Did toba	icco use con	tribute to th	e cause of d	eath?
Hecords,	en si ould t	bed	ucut ro	ual 4	C4 C1	120		,			1 🗆 Yes	2 10 No	3 Prob	ably 4 □U	Inknown
ပ္ထ	aw requ	Completed	TYPESTE	Dias	ets.	Mae	Clica	40			24a. Was an	24b.	Were autor	sy findings a	availabte
r	9 - 6	E	Dames	to	Par	kıu	Len.	Dr.	50	-	autopsy performe	ed?	death?	npletion of ca 2□ No	luse of
Vital	sician: The certificete rector, pag	Bec	25. Was case referred to medical	110-1	,		3 0 7 0				theck only one		1 1 1 1 1 1 1	20140	
> 5	S D	To	examiner? 1 ☐ Yes 2 ② No	ospital:	ent 2□ER	VOutpatien	3 □ DO	Otho			5 🗌 Residen		ner (Specify	•)	
0	ng Pt		27. Manner of Death 1	28a. Date of Inju (Month, Da	ry 28 v Year)	Bb. Time of Injury	28	Bc. Injury Work			I. Describe how			<u> </u>	
<u> </u>	endin eath. or: A he fu	atic	2 ☐ Accident investigation			,,	М		es 2□N	10					
DIVISION	tal or Attendir s after death. al Director: Al ad in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Injuding, etc	ury - At home c. (Specify)	e, farm, stre	et, factory,	office		28f	Location (Stre		er or Rura	Route Num	ber,
ٍ د	ral C			6								,			
	To the Hospital or Attanding Pl within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 11 Certifying Phys	er: On the basis of	t examination	edge, death n and/or inv	occurred a estigation,	it the time	e, date and nion, death	d place, and h occurred	due to the cau	se(s) and ma	anner as st	ated. the cause(s))
	thin 2	Med	29b. Signature and title of certifier	and manner sta	ated.			License							
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		-	20 No.					7	10/0	1		7170	06		
			30. Name and address of person who so	mple ted cause of d	leath (Item 23	sa) (Type, I	rint)	17 0	10	n	1 0	085	57		
s,	Sta	te.	31. Date filed (Month, Day, Year)	32. Begistra	ar's Signature	9 /			1	υγ)(9	00-	- a		
	Registr:		NDD 1 7 21	06	A	i de	32500								j

1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Maider Named Forces or Name Name Name Name Name Name Name Name	Day Year 12
Medical Examiner March M	4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 9. Birthplace (State or Foreign County) Virginia 10d. Inside City Limits 1½ Yes 2 \(\) No 10g. Citizen of What Country? USA or No- 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Domestic iddle, Maiden Sumame) unknown fumber, City or Town, State, Zip Code) MD 21218 20c. Location - City or Town, State Linstowne, Mill Imor Street Balto, MD 21217 Approximate
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Mat. Zion Cemetery O4-12-06 Line	20c. Location - City or Town, State Lansdowne, Mi: Linor Street Balto, MD 21217 Dry arrest. Approximate
Mat. Zion Cemetery O4-12-06 Line	20c. Location - City or Town, State Lansdowne, Mi: Linor Street Balto, MD 21217 Dry arrest. Approximate
**Mt. Zion Cemetery 04-12-06 **Image: Comparison of Compa	Imor Street Balto, MD 21217 Ory arrest. Approximate
Wylie Funeral Home 638 N. Gilmor Str 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) April Funeral Home 638 N. Gilmor Str 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Put E Mon March 1997 Put to (or as a consequence of):	Imor Street Balto, MD 21217 Ory arrest. Approximate
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Immediate Cause (Final disease or condition resulting in death) Amedical The property of the	
/Medical disease or condition resulting in death) A Due to (or as a consequence of):	Interval Between Onset and Death
Due to (or as a consequence of):	1 DAY
Examiner	2.45246
Sequentially list conditions, if any, leading to him addate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) act. C. CITRUNIC OBSTRUCTIVE 2 UNG DISE	DISTASE WARROW
Sequentially list conditions, if any, leading to him addition to cause. Enter Underlying Cause (Disease or injury that initiated events C. CITRUNIC OBSTRUCTIVE 2 UNA DIS	ALLO DIE
cause (Disease or injury that initiated events resulting in death) Last Compared to the compa	DI26736
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Very life of the plant of the p	23d. Date of delivery Month Day Year
yes 21/No	— Say your
Specific program of the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	8:11.1
	Did tobacco use contribute to the cause of death?
1 Yes 2	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown
The second of th	
24a. Was an autopsy performed? 1□ Yes 2 ☑ No 25. Was case referred to medical examiner? 1□ Yes 2 ☑ No 26. Place of Death (Check only one) 1□ Yes 2 ☑ No	Was an 24b. Were autopsy findings available
25. Was case referred to medical 26. Place of Death (Check only one)	autopsy prior to completion of cause of death?
	autopsy prior to completion of cause of death? (es 2 No 1 Yes 2 No
The impatient 2 EN Outpatient 3 DOA 4 Nursing Home 5 Residence	autopsy prior to completion of cause of death? death? 1 ☐ Yes 2 ☐ No
28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury	autopsy prior to completion of cause of death? (es 2 No 1 Yes 2 No
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 38d. Describe how injury 48d	autopsy prior to completion of cause of death? es 2 No 1 Yes 2 No nnily one) Residence 6 Other (Specify)
28d. Describe how injust the property of the p	autopsy prior to completion of cause of death? es 2 ☑ No 1 ☐ Yes 2 ☐ No nnly one) Residence 6 ☐ Other (Specify) ribe how injury occurred on (Street and Number or Rural Route Number.
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Homicide 2 Accident 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 5 Pending (Month, Day Year) 2 Bb. Time of Injury 2 Sc. Injury at Work? M 1 Yes 2 No 2 Bb. Time of Injury 4 Work? M 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 5 Work? A 1 Yes 2 No 2 Bb. Time of Injury 4 Work? A 1 Yes 2 No 2 Bb. Time of Injury 5 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work? A 1 Yes 2 No 2 Bb. Time of Injury 6 Work?	autopsy prior to completion of cause of death? es 2 ☑ No 1 ☐ Yes 2 ☐ No nnly one) Residence 6 ☐ Other (Specify) ribe how injury occurred on (Street and Number or Rural Route Number.
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			1 - For State Registrar	State	of Marylar			t of H	ealth a		ental Hy	giene Reg. No.	006	19	13
	Physici	an	1. Decedent's Name (First, Middle Irene Frances F								Date of De Month	ath Day	Year	3. Time of	
1	/Medic Examir	al er	4a. Facility Name (If not institution Franklin Square	, give street and n				Town, or	Location o		April	4c.	2006 County of Dear Baltimo		Ам
	Funeral Director		5. Social Security Number 231 42 1915	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. 78	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da April	th ly, Year) 6,192	9. Bird Co Vi	hplace (State of buntry) rginia	r Foreign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside Ci	ity Limits
	Mary 9-f eh	tor	Maryland Baltin	ore	Re	osedale	2							1 🗌 Yes	2) No
	th with the 23a or 28	ai Direc	10e. Street and Number 3 Paula Place		· · · · · · · · · · · · · · · · · · ·		10f. Zip	Code 21237	7			_	zen of What Co SA	ountry?	
920	s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23a or 28e-f ehow other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑Widowed 4 □ Divorced	Armed f	2 🛛 No Sive	1	Was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto P	cify Yes or No Rican, etc.)	1	14. Race - Ame Black, Whit Specify: W	e, etc.	
21215-0036	I within 72 ho iene. r than "natur the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 4	t grade completed	() (1-4or 5+)		dent's Usua kind of woi DO NOT us IOMEMA	rk done d se retired)	tion uring most	of workin	g		nd of Business	Industry	
Maryland 2	12 should be filed within in and Mental Hygiene. 7 is marked other than " raumatic event, the Men	To Be C	17. Father's Name (First, Middle, Lemuel Wimmer	Last)						r's Name ia Co	(First, Middle,	, Maiden .	Sumame)		
Man	12 sho h and h and 7 is mu		19a. Informant's Name/Relations! Virginia W. Gray		. \						Route Number, Mary		Town, State, 2	Zip Code)	
_	of Health of Hea		20a. Method of Disposition	(precer		Place of Dispo					ate Trically		cation - City or	Town, State	
E O	Pages nent of I int: If it		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S _i	3 □Removal from Decify)		cemetery, cren yview C			4,	/17/2	2006	Balt	imore,	Marylar	nd
Baltimore	permit. Pages Department of Important: If Ii eny Injury or o		21. Signature of Funeral Service I	urkruz	ke	E	Name an Bruzdz 407 (zinsk	i Fur	neral	Home enue E	P.A.	, Maryl	and 212	221
8760,	by Medical by the death certificate be executed by the ettending physicien and be detached for use as the burial-transit	dical Examiner	23a. Parl 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a consect	n Macquence of):	la	c f	lbru	llafi	m			Approximating and Interval Bet Onset and I	ween
P.O. Box 68	Physicien: The law requires that the death certifica this certificate has been signed by the ettending ph rail director, page 2 should be detached for use as it	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregn birth 2 ☐ Feta gnant at time of c nown	al death 3	Ectopic pro Other (sp.					2	3d. Date of del Month	,	Year
	w requires that been signed b should be deta	by	Part II, Other significant condition	ins contributing to	Cancu	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	\	1	the cause of dobably 4 Du	
Il Records,	: The law recate has be page 2 sho	Completed	<i>/</i>	Appert	ens (or						24a. Was autor perfo 1 Yes		death?	itopsy findings a completion of ca	available ause of
of Vital	siclen certifii rector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2∑ No	Hospital:		7.5010		Othe	-		(Check only o				
ion of	ding After fune	ation: To	27. Manner of Death 1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investig	28a. Date (Mo	Inpatient 2X e of Injury enth, Day Year)	28b. Time of Injury		8c. Injury Work	4 🗀 1901	21	e 5 ∐ Resid 8d. Describe I		Other (Spendocurred	cify)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune.	Medical Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 289. Plac	ce of Injury - At h ding, etc. <i>(Speci</i>	iome, farm, str fy)	eet, factory	, office		21	8f. Location (S City or Tov	Street and wn, State)	Number or Ru	ıral Route Num	ber,
	Hosp 24 hou Fune stely fil	dical	29a. Certifier (Check only one) **Certifyin 2 ■ Medical I	g Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	owledge, death ation and/or inv	occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, ar h occurre	nd due to the d at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	n			29c	. License	number			29d. Date	signed (Mont	h, Day, Year)	
	1		1 / whi	heas.	mo		100	458	376			04	117/0	16	
	γ'		30. Name and address of person of the state	20 Cam	p bell	Bluc	0	Bal	hm	ore	, MD) 0	1236		
	Sta Registr		31. Date filed (Month, Day, Year) APR 1	7 2006	Hegistrar's Sign	ature	arts)								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20a-c,22,perrh.G356,6/21/66 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2006 Mary M. Kroening Apr 3, 6:20 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Heritage Center Dunda1k Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 💢 F Director 85 220-05-8233 <u>Maryland</u> Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heatth and Mantal Hygiene. em 27 is marked other then "natural", or Itams 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or itams 23a or 28a-f show other treumatic event, the Madical Examinal must be nutilised at 1 ☐ Yes 2 ☑ No Director Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7232 German Hill Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ If Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 0 accounting clerk healthcare 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Whipp Helen Schemn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dapartment of Heatth a Importent: If item 27 is eny injury or other tre <u>once.</u> William Macher/son 1001 Gladeway Road Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory 6/16/2006 * 4 □ Donation 5 □ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc 299 Frederick State Anatomy Board 555 W. Baltimore Street Road 21. Signatur of Funeral Service Licensee Ronald S. Ma Board 655 21201 21228 Baltimore, MD 2120121228

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, repeat lailure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death CORONARY ARTERY PISEASE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit DEMENTIN Due to (or as a consequence of) attending physician Box 68760 that the death certificate be Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.O. the detachad 9 Unknown 9 Unknown been signad by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificata has autopsy 1 Yes 20 No 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No ပ 2 ER/Outpatient 3 DOA this 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification; 1 Natural 2 Accident 5 Pending investigation after death. Μ 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospitel within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 1,23a pt II per doc 854 4-17-06 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Knox Sandra **Physician** Month Day Year ANG /Medical 544 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rawdell Tours tel Waitimese NUS-th 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign
 Qountry) **Funeral** 218-46-9216 Usual Residence of Decedent Days Hours 1□M 20 F Min Director Yrs ar 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other then "natural", or items 23e or 28e-1 show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 17 is marked other then "natural", or items 23e or 28e-f show treumatic event, the Medical Exam and must be notified at 1 Yes 2 □ No Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 212 Completed by Funeral ve 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify: 3 Widowed 4 □ Divorced a 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a, Informant's Name/Relationship (Type, Print) yn le 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 is eny injury or other treu once. 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State Memorial 12006 ina 22. Name and Address of Facility 21. Signature of Funeral Service Licensee uneral Home, Balto Maiziz seph u W. North Ave. Parti. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a 525th intestinal disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ò in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 DrNo 9 ☐ Unknown Division of Vital Records, P.O. the a detached 9□ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No Completed 1 🗌 Yes 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 XNo 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Certification: To Other: 1 ☐ Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wich / 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DACH WAST 1-11-40 32. Registrar's Signature Date filed (Month, Day, Year) State APR 0 4 2006

Registrar

06-02052 Robert E. Lee

Amend Item 8 per Ct Order G907 9/24/10 & Item 7 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Amend Item #9,16a&b, 18&19a Pertificate of C894 4/17/06 JH Reg. No. 1 (2. Date of Death 2. Date of Death Month **Physician** 2006 Robert E. Lee March 15:40 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 703 Washington Avenue Chestertown Kent 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Birthplace (State or Foreign Country) 1 ☑ M 2 □ F unk Director 59 Yrs. Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Directo 1 ☐ Yes 2 ☐ No Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ unk or items 23a 703 Washington Avenue Funerai 21620 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: unk Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed white 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry se filed within 7 al Hygiene. unk Elementary/Secondary (0-12) College (1-4or 5+) Brick Layer Commercial Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental Important: If Item 27 is marked or any injury or other traumatic eve once. unk Helen Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Unknown O.C.M.E. Charles Lee/brother 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State. 4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald State Anatomy Board 655 W. Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Atheroscherotic Cardiovascular Diseas. **Physician** /Medical Due to (or as a consequence of): Complicated by Hypothermia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: for use 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) Dav 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an performed? 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1X Yes 2 □ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) SCENE Certification: 27. Manner of Death 28a. Date of Injury
Founds, Day Year)
3/23/06 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide To the mospine within 24 hours after death.

To the Funeral Director: Alt Fruit P 5 | Pending Exposure to Low investigation 1☐Yes 2ĂNo envivonmental temperature 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 703 Washington Ave 4 Homicide Allec Cheskertown MD Medical to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Carol HAllanna 31. Date filed (Month, Day, Year) State 32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

APR 1 7 2006

			For State Registrar	State of Marylar	-	artment of H			iene		19	1-7
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th	Vear	3. Time of I	Death
	Physicia /Medic		Albert Charle	es Messer	iger	,		April	09 ^{Day}	2006	5:30	Рм
	Examin		4a. Fecility Name (If not institution, give st			4b. City, Town, o		Death		y of Death	اماما	
			1213 Overview Driv 5. Social Security Number 6. Sex	7. Age (In yrs	In a thinth day.	If Under 1 Year	sadena If Under 24	4 Hrs Data of Bigh		ne Aru		. Caraina
	Funeral Director			M 2 F	67 Yrs.	Months Days	Hours	4 Hrs. 8. Date of Birth Min. (Month, Day OCt. 19	1938	Countr	ice (State or y) MD	roraign
			Usual Residence of Decedent					1000. 15				
	nylan show	_	10a. State 10b. County		ity, Town or Lo	ocation				10	 Inside Cit Yes 	•
	Ba-f e	cto	Maryland Anne Aru	ndel Pa	sadena	1			- 0::: .			2 (Z)(40
	s 1 and 2 should be filed within 72 hours after deeth with the Maryland If Heelih and Mental Hygiene. If Heelih and Mental Hygiene. If the 23 or 28 or 28 ar 8 how other traumatic event, the Mudical Examinar must be notified at	Funeral Director	10e. Street and Number 1213 Overview Driv	е		10f. Zip Code 21122			0g. Citizen of USA	what Count	ry r	
	eme 2	ner	11. Marital Status	2. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origi an, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)		ce - America ack, White, e		
36	s afte	by FL	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 √Yes 2 No If Yes, Give 55	5-58	1 ☐ Yes 2 ☐ No	Specify:		Speci	ரு: whi⁻	te	
Ö	hour Itural	ed b	15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usual Occur	pation		16b. Kind of E	Business/Indu	ıstry	
15	within 72 ene. then "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most (d)	of working			·	
212	giene giene er the	E O	12		En	gineer	1			railro	ad	
b	be filed tal Hygie d other event,	Be	17. Father's Name (First, Middle, Last)					's Name (First, Middle, .			_	
Œ	should to and Ment marked umatic	7	7112010		lesseng		Mar	1 C or Rural Route Number		ttleto		
Mai	d 2 st th and Tie m traun		19a. Informant's Name/Relationship (Type Mildred Mary Messe			-		e Pasadena			2006)	
<u>ق</u>	Heelth Heelth tem 27 other tr		20a. Method of Disposition		Place of Disp	osition (Name of	1		20c. Location		rn, State	
ē			1 ⊠Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		matory`or other pla		/13/2006	Glen Bu	ırnie.	Marvla	and
Baltimore,	글 된 원 등 .		21. Signature of Funeral Service License	The second secon	the state of the s	2. Name and Addre	×	the state of the s				
ä	Depa Impo Impo eny ii		by d. St	77	3	111 Mount	tain Ro	oad Pasaden	a MD 2		C 1 .//.	,
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the dea	ath. Do not en	ter the mode of dyi	ng, such as c	ardiac or respiratory arr	est,	. 1	Approximate Interval Betw Onset and D	ween
	Physician		Immediate Cause (Final disease or condition	lend	Cel	l Ca	nei	noma		6	Moi	
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
		er	Sequentially list conflicts if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a conse	quence of):							
1	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
0	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a conse	quence of):							
87	physic s the bu	dical	d.							-		
9 X	eath certifica attending pl	/Me	IF FEMALE:	Bc. If yes, outcome of pregi	nancv				23d D	ate of deliver	v	
Вох	a attend	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		⊒Ectopic pregnanc ⊒ Other (s <i>pecify</i>) _	У					/ear
P.0	by the detected	hys	9 Unknown	9□ Unknawn				- 1				
	The law requires that the death certificate ate has been signed by the attending phys page 2 should be deteched for use as the	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the i	underlying cause gr	ven in Part I.		bacco use cor es 2 □ No	ntribute to the	~	leath? Jnknown
Records,	w requir been si should	Completed						24a. Was a			. (-\	
Rec	The taw cate has page 2 s	mp						autop:	sy magal?	death?	pletion of ca	luse of
_		0	25. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only or	2/23(No	1 ☐ Yes 2	! ∐ No	
Ξ	ysicie is cert direct	OB	examiner?	ospital: 1 🗌 Inpatient 2 [☐ ER/Outpatie	nt 3 DOA	hor	sing Home 5 Resid		ther (Specify)		
n of	Attending Physicien: or death. ector: After this certification by the funeral director.	Di:T	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju	ry at rk?	28d. Describe h	ow injury occu	irred		
Sio	death. ctor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 N					
Division	after d after d Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		treet, factory, office		28f. Location (S City or Tow	n, State)	iper of Hurai	Houte Numi	<i>767</i> ,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier Certifying Phys (Check only one)	ician: To the best of my killer: On the basis of examiliand manner stated.	nowledge, dea nation and/or i	th occurred at the the threating the stigation, in my	ime, date and opinion, deati	d place, and due to the o	ause(s) and n late and place	nanner as sta , and due to	ited. the cause(s))
	Fo the	Me	29b. Signature and title of certifier			29c. Licen	se number	r :	29d. Date sign	ed (Month, D	ay, Year)	
) man	or		D	395	05	4 pm	(10,	200	6
	1241		30. Name and address of person who co	mpleted cause of death (Ite	- 1 1	Print)	mi	ve, Glen	Bur	vi e	MD	a 4
	-0		31. Date filed (Month, Day, Year)	32 Registrar's Sig		and)		7 4.		7	210	61
3	Sta Regist	ate rar	APR 1 7 20		15 M	Mr. Again						

			For State Registrar	State of Maryland		rtment of h			giene Reg. No:	06	1918
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Glenwood	Е		Meri	ca	2. Date of De	ath Day	ZVV6	3. Time of Death 6-736 MM
	Examir		4a. Facility Name (If not institution, give si	rytan Machi	cal C	inter,	Location of Deat	Burni	1 12	nty of Death	Avnala)
	Funeral Director		214-54-7617	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da March	22 ^{ea} 195	9. Birth	place (State or Foreign ntry) yland
	the Maryland 28a-f ehow notified at	JO.	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru		Town or Loc Pasadei						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the Mi 23a or 28a-f	Funeral Director	10e. Street and Number 8076 Catherine Ave			10f. Zip Code 211	22		10g. Citizen o	of What Coul	ntry?
36	er dea	by Funera	11. Marital Status 1. 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1		las Decedent of H Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer Specity:	specify Yes or No to Rican, etc.)	- 14. F	ace - Americ lack, White,	etc.
Baltimore, Maryland 21215-0036	hin 72 hour e. en "naturel Medical E.	Completed t	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of wo.	rking	16b. Kind of	Business/In	
nd 21	be filed withintat Hygiene. d other therevent, the M	Be	12 17. Father's Name (First, Middle, Last)		Li	nesman		me (First, Middle,			
Maryla	s 1 and 2 should be filed v if Health and Mental Hygies Item 27 is marked other to other traumatic event, ID	ဥ	Glenwood Forest 19a. Informant's Name/Relationship (Typ Leslie L. Merica	Merica , Print) spouse			Ida and Number or Ro erine Avo			Marti m, State, Zip 2112	Code)
nore, I	ages 1 and 2 int of Health t: If Item 27 i		20a. Method of Disposition 1 \(\forall \)Burial 2 \(\text{Cremation} \) 3 \(\text{Re} \) 4 \(\text{Donation} \) 5 \(\text{Other} \(\text{(Specify)} \)	20b. Pla	ace of Dispos metery, crem	ition (Name of atory or other pla		Date	20c. Locatio	n - City or To	own, State
Baltir	permit. Pages 1 am Department of Heali Important: If Item 2 any injury or other 2005.		21. Signature of Fyneral Service License	/	22.	Name and Addre	ss of Facility S- tain Road	tallings		al Horr	
m 4/2) 69) 8760,	bath certificate be executed with the continuation of the continua	dicai Examiner	23a. Part1. Enter the disease, or complessore, or heart failure. List only of shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseque	ence of):		ng, such as cardia	c or respiratory a	rest,		Approximate Interval Between Onset and Death
⊘ ⇔ ℓ(.o. Box 6€	the death certifica y the attending ph ched for use as t	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of deal 9 Unknown	death 3□E	Ectopic pregnancy Other (specify) _	,			Date of delive Month	ery Day Year
y W rds, P.	w requires thet the de been signed by the should be detached	d by Ph	Part II. Other significant conditions cont.	ibuting to death but not resul	lting in the und	derlying cause giv	en in Part I.	23e. Did t		_	he cause of death?
Xy	The lay ate has page 2	Complete						24a. Was autor perfo 1 □ Yes			ppsy findings available mpletion of cause of
$\left\langle \begin{array}{c} \left\langle \cdot \right\rangle \\ \text{Division of Vita} \end{array} \right $	onding Physician: The sath. or: After this certificate the funeral director, pag	Certification: To Be	27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	1	R/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 🗌 Nursing H	ath Check only of dome 5 Resid	dence 6 🗆 C		(y)
Divis	itel or Att irs after de ral Direct	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)				City or Tox	vn, State)		al Route Number,
(1)	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 2 Medical Examination) 29b. Signature and title of certifier	cian: To the best of my know it: On the basis of examination and manner stated.	rledge, death on and/or inve	occurred at the tir estigation, in my d	pinion, death occu	irred at the time,	cause(s) and date and place 29d. Date sign	e, and due to	the cause(s)
	F 3 F 8		30. Name and address of person who com	Inpleted cause of death (Item)	23a) (Tyne P	DYS	3006		04/1	2/2	006
	Sta	te	31. Date filed (Month, Day, Year)	32/Registrar's Signatu	30)	Hosp	ital B	V., 6	ا سو	Syr	July MD
	Registr		APR 1 7 200	Stores 15	Again	(L)					

Registrar

			1- State Registrar	", State of M	arytan		artment of H tificate of			lental Hy	giene Reg. No	000	11920
	Physic	an	1. Decedent's Name (First, Middle, La							2. Date of De	eath Day	y Year	3. Time of Death
	Physici /Medi		DOROTHY	MERRI	TT					APRIL		2006	445 A M
	Examir	er	4a. Fecility Name (If not institution, gir				4b. City, Town, o	r Location	of Death		4c.	County of Deat	h
			Genesis Multi-Mo				Towson				I	Baltimor	e
	Funeral Director		002-03-5017 002-30-5017	Sex 7. Ag 1 □ M 2 🖔 F		38 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da SEP 14	19. Year)	9. Birti Co	hplace (State or Foreign untry) NH
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	the Maryland r 28a-f show	ō	MD Baltimo	ore		wson							1 ☐ Yes 2 X No
	28a	Director	10e. Street and Number) <u> </u>	10	WBOII	10f. Zip Code				10a Citi	izen of What Co	
	death with the Maryland ms 23a or 28a-f show fmust be notified at	Ö	106 La Paix Lane	2			2120	4			17	JSA	
	death	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S		Vas Decedent of H	lispanic Or	igin? (Spe	cify Yes or No		14. Race - Amer	ncan Indian,
920	or ite	by	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No		Yes, specify Cuba	Specify:		Rican, etc.)		Black, White	o, etc. hite
0	72 hours "natural",	ted	15. Decedent's E	ducation		16a. Deced	ent's Usual Occup	ation		-	16b. Ki	ind of Business/I	
21215-0036	s 1 and 2 should be filed within 7 f Health and Mental Hygiene. item 27 is marked other than "r other traumatic event, the Mark	Completed	(Specify only highest gn Elementary/Secondary (0-12)	College (1-4or 5	i+)	Homem	kind of work done DO NOT use retired aker	during mos i)	st of workin	ng		n Home	•
ğ	e filec I Hyg othe /ent,	Ø	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,			
Maryland	and 2 should be alth and Mental 127 is marked o	To B	Grover Clevelar	nd Millen	2			Ann	ie	Martha	G	risenth	waite
ary	and A	_	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street	and Numbe	er or Rural	Route Numbe			
	and 2 allth a		Harry W. Merritt	- son		106 L	a Paix L	ane,	Tows	on, MD	212	204	
ore.	of He of He item		20a. Method of Disposition		20b. Pla	ace of Dispos	sition (Name of place)			ate	20c. Lo	cation - City or 1	own, State
Ē	Page nent o int: If	Ì	1 ☐ Burial 2 🕅 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special				e Cremato	1	4/15/	/2006	Re1	tsville	MD
Baltimore,	permit. Pages 1 an Department of Heali Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice		100986	22. S	Name and Address AFA, Step 717Green	ss of Facility Phen Pact	D. Lo	hrmann	, PA	Zon MD	21206
		\dashv	23a. Part1. Enter the disease, or com	plications that caused	the death.	. Do not ente	r the mode of dyin	g, such as	cardiac or	respiratory as	rest,	SOII, PID	Approximate
	Physician		Immediate Cause (Final	one cause on each ill	0515								Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to /or as	2 000000111	ence of):					-		100 10
	Examiner	- G-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as		Q Y	TRAC	7	INI	FECTO	Or	√	Days
V_	xecuted and il-transit	xamin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. NE 1	120	Gen	110	BLA	4DD	ER		r	nontre
68760,	ficate be executed physician and s the burial-transit	edical Examiner	(d Deve								7	nontro
	ding		IF FEMALE:	23c. If yes, outcome	of ======								
P.O. Box	The law requires that the death certificate be executed at the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at	2 Fetal o	death 3 □E	Ectopic pregnancy Other (specify)		· · · · · · · · · · · · · · · · · · ·		2	3d. Date of deliv Month	rery Day Year
	that ed by deta		Part II. Other significant conditions of	ontributing to death bu	ıt not resul	ting in the un	derlying cause give	n in Part I.		23e. Did to	bacco us	se contribute to	the cause of death?
Sp	w requires that been signed b should be deta	d by										No 3□Pro	
Õ	w req	lete		· · ·						04-146-		24 14	
of Vital Records,	The law ate has page 2 s	Completed								24a. Was autop	sy	prior to co	opsy findings available empletion of cause of
ā	10 -		25. Was case referred to medical						15		2 NO	1 ☐ Yes	2 No
Š	Physician: this certificanal director,	To B	examiner?	Hospital: 1 Inpatie	m 2□⊏	R/Outpatient	3□ DOA Othe		-	(Check only o			
of	ding Physician: After this certific funeral director,		27. Manner of Death	28a. Date of Injur	y 2	28b. Time of	28c. Injury Work			e 5 🗆 Hesid 3d. Describe h		Other (Special	(y)
on	ding I	I S	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year)	Injury		:? /es 2 □ N			, ,		
Division	Attencr death	100	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ry - At hom	ne, farm, stree	et, factory, office		28	Bf. Location (S	treet and	Number or Run	al Route Number,
Ö	s afte s afte at Dire	Certification:	4 Homicide determined	building, etc	. (Specify)		,			City or Tow	n, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edicai (29a. Certifier (Check only one)	ysician: To the best of niner: On the basis of and manner sta	examination	ledge, death on and/or inve	occurred at the timestigation, in my op	e, date and inion, deat	d place, ar th occurred	nd due to the o	ause(s) a late and p	and manner as s place, and due t	tated. o the cause(s)
	Withir Comp	Σ	29b. Signature and title of certifier				29c. License					signed (Month,	
			Sount	e MD			0.00	531	C_{1}		PR	11 ,30	72006
	Λ		30. Name and address of person who	completed cause of de	ath (Item 2	23a) (Type, P	rint)	۱۰ ر			11 00	(0)	UNRIA
	7		Spuph 30. Name and address of person who Shawwayana	CUPTA	965	0 57	NTIAC	o de	AD	JUIT	EII	0 000	0 71045
	Stat		31. Date filed (Month, Day, Year)	32. gistra	r's Signatu	ге	V						0,013
DI	Registra	ar .	APR 1 7 21	006 006	w h	19		<u></u>					

	•	1 - For Amend Item 2	23a per di	L.,6054,09	Hiticale of	Death		2006	11921
at 13 g 2	*	Registrar 1. Decedent's Name (First, Middle, Last)			Timouto or	Dout.	2. Date of De	31 31 37	3. Time of Death
Physicia	an	TALMADGE EMANU		ONG			Month	Day Year	r
/Medic	al			IONS			04	11 200	
Examin	er	4a. Facility Name (If not institution, give s				or Location of Deat	th	4c. County of De	oath
	y 4			HOSPITAL		IMORE		N/A	
Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday,	If Under 1 Year Months Days		(Month, Da	th y, Year) 9. B	irthplace (State or Foreign Country)
Director		217-24-1340	1W 201	7.4 Yrs.			09/12	/1931 M	MARYLAND
pu ,	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	nonting.	-			10d. Inside City Limits
aryla shov	-					7			1X Yes 2 No
9 M	cto	MD N/A		BALTIMO	ORE CITY	L			145 Tes 2 No
th th or 28	lre	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
death with the Maryland me 23a or 28e-f ehow r must be notified at	Funeral Director	2852 W. NORTH 7	AVENUE		2121	16		USA	
er dea Iteme	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No	14. Race - Ал Black, Wh	nerican Indian,
after or Its		1 Never Married 2 Married	1 ∑Yes 2 □ N If Yes, Give	□ AIR	1 Yes 2 No		to Thourt, etc.,	Specify: BI	
raff,	by	3 ☐ Widowed 4 X Divorced	Year or Dates:	FORCE	ILL TES ZALINO	эрөспу.		Specify: DI	JACK
72 hours after natural, or Its olical Exemira	tec	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	edent's Usual Occu	upation e during most of wo	rkina	16b. Kind of Busines	ss/Industry
thin B.	ple	Elementary/Secondary (0-12)	College (1-4or 5-	life	DO NOT use retire	ed)	rang		
d will gien er th	Completed	12TH	2 YEARS	MUS	SICIAN			ENTERTA	AINMENT
othy Vent	0	17. Father's Name (First, Middle, Last)						, Maiden Surname)	
lenta lenta rked	To B	HENRY NIMMONS				ETH	IEL MUR	DOCK	
shound N	_	19a. Informant's Name/Relationship (Typ						er, City or Town, State,	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene Importent: if item 27 is marked other than "natur any injury or other treumatic event, it a Madical once.		BEATRICE G. RAN	DOLPH /S	SISTER 44	407 THE	ALAMEDA	A, BALT	IMORE, MI	21239
1 ar Hea Hean Sthe		20a. Method of Disposition		20b. Place of Disp	osition (Name of	1	Date	20c. Location - City of	
Pages nent of int: If it		1 Burial 2 Cremation 3 □R	emoval from State	MD VETI	TRANS CI	<u>EM</u> 4/1	8/06		MILLS, MD
t. P.	14	4 □ Donation 5 □ Other (Specify)		+ GARRISO	ON FORES	ST			HOME 21207
permi Departimpos tmpos any ir		21. Signature of Poneral Service License							
20 % e a		// Mugues	0.	2-00					rimore, MD
		23a. Party. Enter the disease, or complice shock, or heart failure. List only on	cations that caused ne cause on each lin	the death on not en	nter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease of condition	200-	ASp1	ration	Pneumoni	a		Onset and Death
/Medical		disease of condition		1 11 11 11					
Examiner	. 1	resulting in death)		a consequence of):					
EXCITITIO!			Due to (or as a	a consequence of):	1				
	ier		Due to (or as a		1				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitional Certification: To Be Completed by Physician/Medical E-Medical Certification:	5	det	uld not be ermined	e		- At nome,	farm, street	ractory, c	atice bui	iding, etc.	unk or To	tion (Stree wn, State)	ı and N umber ör I	Rural Route Number, Cit
Lospii 4 houn 'unner.'sly fill		29a Certifier 1 Continues	hvsicis			nowledne d	eath occurr	ed at the ti	me data	e and place ar			and manner as st	arted
To the Howithin 24 To the Fucompletel	3	Check only	aminer:	On the basis	of examina								place, and due to	
To With	2	Signature and title of certific		and manner s	stated.			29c I	License i	number		290	Date signed (A	Month Day Year)

Registrar

ss of person who completed cause of death (Item 23a)

29c. License number O.C.M.E.

April 8, 2006

29d Date signed (Month, Day, Year)

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Pay Year) 7 2006

ORIGINAL

			For State			ınd / Dep	artment	of Health and	•	_	ie.
			Registrar			Ce	rtificate	of Death	F	Reg. No.	0 11340
	Physici /Medi		Decedent's Name (First, Middle, La		ty Mil	dred Pe	rrera		2. Date of Dea Month	_	Yeer 6 S;/4 PM
	Examir	ner	4a. Facility Name (If not institution, giv	1	umber)	1.1	4b. City, T	own, or Location of De	eath	4c. County of	f Death
			1	are 1-	tospi	tal	K	Sedale		1 Bal	timore
	Funeral		5. Social Security Number 6. S	Sex I⊡M 2½∏ F		s. last birthday,	If Under 1 Months		Hrs. B. Date of Birtl (Month, Day	h y, Year)	Birthplace (State or Foreign Country)
	Director		214-20-6765		74	Yrs.			Sept. 1		Maryland
	land	ļ	Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or L	ocation				10d. Inside City Limits
Ly	Many	Ö		7				-	7 71		1 ☐ Yes 2 No
1	1 the	e c	Maryland Book 10e. Street and Number	altimor	e		10f. Zip 0		ındalk	10g. Citizen of Wh	nat Country?
3	ours after death with the Marylar ral', or Items 23a or 28a-f show Examiner must be notified at	Funeral Director	856 Mildred Av	۵.				2122		United	
(8	deat	ner	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was Decede	ent of Hispanic Origin? fy Cuban, Mexican, Pu			- American Indian,
ဖွ	after or Ite	F	1 Never Married 2 Married	Armed F 1 ☐ Yes If Yes, G	2 🔀 No				ierto Rican, etc.)		, White, etc.
~~ 5-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28a-f show he Madigal Examinar must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or [1 ☐ Yes 2	IX No Specify:		Specify:	White
2 2	natu	Completed	15. Decedent's En (Specify only highest gra	ducation ade completed;)	16a. Dece (Give	dent's Usual kind of work	Occupation done during most of a retired)	working	16b. Kind of Busi	iness/Industry
2(0	Withir Page 1	ш	Elementary/Secondary (0-12)	College ((1-4or 5+)						
d 2	be filed tal Hygie d other svent,	ပို	9 Years 17. Father's Name (First, Middle, Last,)			Waitre		Name (First, Middle,		urant
r and	og ta b ≥	o Be	Wilbur Phyles						a Ashley	Maiden Sumame)	
210	should to and Ment is marked	2	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	na Address (Street and Number or		r City or Town S	tate. Zin Code)
Q E	d 2 2 7 1 s		Mr. James Zito (Law)				w Freedom		349
Baltimore,	is 1 and of Heali itsm 2 other		20a. Method of Disposition		20b.	Place of Dispo	sition (Name	9 of	Date	20c. Location - C	ity or Town, State
Ĕ	permit. Pages Department of I Importent: If Its any injury or or once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐	Removal from y)	U.O.M.			ce Corp. 4	/15/2006	Towson,	Maryland
ä	permit. Departn Importe any inju		21. Signature / Virieral Sevice Liter	AGE V	1111			Address of Facility ICK Funeral		Dundall-	Two
<u> </u>	Dep imp		Med 111	1 / E	nug			ise Ave.	Dundalk, 1	Maryland	Inc. 21222
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on o	caused the dea	ath. Do not en	er the mode	of dying, such as card	liac or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	5	20519	5					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	equence of):)	A A 8			
		_	Sequentially list conditions,	b. HSY	inati	00	nel	Monto	2		
V	ed sslt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):					
ν,	be executed icien and burial-transit	хап	that initiated events resulting in death) Last	c	(or as a conse	guence of):					
,092	builcie	cal E	l			4					
687				. d							
ŏ	eath certifical attending phy for use as th	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregr					23d. Date	of delivery
<u> </u>	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregr	birth 2 Fet nant at time of		Ectopic preg Other (spec			Month	-
Ö.	that the death ed by the atte detached for	hys	9 🗆 Unknown	9□ Unkn	own				,		
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pro	w requir been si should I	ted	Acute Ren	iar	talli	110			_ 1 ☐ Ye	es 2 No 3	☐ Probably 4 ☐ Unknown
Ö	e lawr hes be	Die.	COTD						24a. Was a		ere autopsy findings available
=	The sete h	Completed	DM						perform	med? dea	or to completion of cause of ath? Yes 2 No
/ita	iclen: Th	Be	25. Was case referred to medical examiner?						eath (Check only on	18)	
of	Physic this cal dir	2	1 ☐ Yes 2 No 27. Manner of Death			ER/Outpatier			Home 5 ☐ Reside		
E C	ding After funer	tion	1 XNatural 5 ☐ Pending		th, Day Year)	28b. Time of Injury	M 280	C. Injury at Work?	28d. Describe ho	ow injury occurred	
<u></u>	deat deat ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not be		of Injury - At I	nome, farm, str		1 ☐ Yes 2 ☐ No	28f ocation (St	treat and Number	or Rural Route Number,
Θ	after after Dire	Certification:	4 Homicide determined	buildi	ing, etc. <i>(Sp</i> ec	ify)	561, 120101 y , 0	Silice	City or Town	n, State)	or nurar noute Nurriber,
	spite hours meral		29a. Certifying Ph	ysicien: To the	best of my kn	owledge, death	occurred at	the time, date and pla	ce, and due to the ca	ause(s) and mann	er as stated.
	To the Hospital or Attanding Physicien: The law within 24 bours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, pege 2	Medical	(Check only 2 Medical Exam	uner: On the b	asis of examin ner stated.	ation and/or in	estigation, in	my opinion, death oc	curred at the time, de	ate and place, and	due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1			29c. L	License number	2	9d. Date signed (i	Month, Day, Year)
			Ofmande	5				5863		April	12,2006
	5		30. Name and address of pason who o	completed caus	se of death (Ite	m 23a) (Type,	Print)		0.11	0000	nd ninna
1000		K	DK Shering , 31. Date filed (Month, Day, Year)	4/11do	7000 -	trank,	in Sq	ware Dri	ie Balti	Move 1	110 d/d5)
	Sta Registra		APR 1 7	2006	gistiat s sign	K A	mertis				

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			1 - For State Registrar	State of M	arylan	id / Depa <i>Cei</i>	artme <i>rtifica</i>	ent of H ate of L	ealth a D <i>eath</i>	and M		giene Reg. No.		6	119	21:
	** # # 1		1. Decedent's Name (First, Middle, La	st)							2. Date of Dea				3. Time o	of Death
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	Examir		4a. Facility Name (If not institution, giv	e street and number))		4b. Ci	ty, Town, or	Location	of Death	1		County o			
			Manor Care Ross	ville Nurs	sing	Home		Rossv	ille				Bal	timoı	re Co.	
< /	Funeral		5. Social Security Number 6. S	6ex 7. Ag		last birthday)		ler 1 Year	If Under		8. Date of Birt	h Vanal		9. Birthpl	ace (State	or Foreign
	Director		216-20-6908	X M 2 ☐ F	80	Yrs.	Month	s Days	Hours	Min.	(Month, Day April	L, 19	26	Mary	yland	
	D _		Usual Residence of Decedent													
	how	_	10a. State 10b. County	_ 1	10c. Cit	y, Town or Lo	cation		T					10	Od. Inside C	•
	Ba-f of	Director	2	Baltimore					Edger	nere					1 🛄 Yes	s 2Ã No
	or 2	Olre	10e. Street and Number				10f. 2	Zip Code				10g. Citi	zen of W	hat Count	try?	
	23a	- E	3109 Greenhill R	oad					212	219		Un	ited	Stat	tes	
	r dex	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13. \	Was Ded	edent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)			- America	an Indian,	
9	or the	by Fu	1 Never Married 2 Married	1X Yes 2 ☐ If Yes, Give	No			2 X No	Specify:		, ,		Specify:			
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ប៉	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or terms 23a or 28a-f ehow atto event. It a Mudical Exerction must be rodified at	Completed	15. Decedent's E- (Specify only highest gra			(Give	kind of I	sual Occupa work done o	luring mos	t of worki	ng	16b. Ki	nd of Bus	iness/Ind	ustry	
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Š	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturat", or ttems 23a or 28a-f show aumatic event. It a Madical Examinatinatinal banoulied at	7	40- 1-6	T 02-1												
maryiand	- C - 5		19a. Informant's Name/Relationship (Mr. Joseph D. Pic		Son)			ss (Street a st Ja:			Route Numbe	_			_	21050
	ss 1 and of Heelth ttam 27 other tr		20a. Method of Disposition	CIOWSKI (lace of Dispo			TIEL		le Roa				11, M	ID
0	Pages nent of h int: If tta iry or of		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	C	emetery, cren	natory o	r other place					cation - C	City or Tov	wn, State	
	tmer tant tant		4 □ Donation 5 □ Other (Specif	-	St						15/200				, Mar	yland
baltimore,	permit. Pages Department of I Important: If tt any Injury or o		21. Signature of Funeral Service Licer	isee		Di	. Name 1da-	and Addres Ruck]	s of Facilit Funer	al H	ome of	Dund	lalk.	Inc		
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א מ	death certifti e attending I ad for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			lEctopic	pregnancy				2		of deliver	-	
	0 0 0	sici	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	4☐Pregnant at 9☐Unknown	t time of de		Other (Mont	h [Day	Year
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ń	law requires that the de. as been signed by the a 2 should be detached fo	by	Part II. Other significant conditions of					cause give	n in Part I.		23e. Did to	bacco u	se contrib	ute to the	e cause of	death?
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N II a	an: tifica tor. p	o .	25. Was case referred to medical				_		26 Place	of Death	1 ☐ Yes	2 100		Yes 2	2 [] NO	
>	ysici	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆	ER/Outpatien	t 3 🗆 🛭	Othe			ne 5 ☐ Resid		□Other	(Canada)	1	
5	eral eral	2	27. Manner of Death	28a. Date of Inju	iry	28b. Time of	_	28c. Injury	at		8d. Describe h				,	
	ath. r: Aft	ate	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y rear)	Injury	М	Work 1 ☐ Y	? ′es 2 ∐ ≀	No						
2	Attending Physician: It death. Sector: After this certifice by the funeral director.	Certification;	3 Suicide 6 Could not be determined	286. Place of Inj	ury - At ho	me, farm, stre	eet, facto	ry, office		2	8f. Location (S			or Rural	Route Nun	nber,
5	ell or	ert	4 Homicide	building, et	c. (Specify	")					City or Tow	n, State))			
	spite	ai	29a. Certifier 1 - Certifying Ph	ysician: To the best	of my kno	wledge, death	occurre	d at the time	e, date an	d place, a	nd due to the c	ause(s)	and man	ner as sta	ited.	
	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	one) 2 Medical Exam	niner. On the basis of and manner sta	i examınai	tion and/or inv	estigation	on, in my op	inion, deal	th occurre	d at the time, d	ate and	place, an	d due to	the cause(s	s)
	To th	Me	29b. Signature and title of certifier				2	9c. License	number		2	9d. Date	e signed	(Month, D	ay, Year)	
			1 About					050	201	1		1.	3/2-			
	inx	+	30. Name and address of person who	completed cause of d	leath (Item	23a) (Type 1	Print)	055	500	O		7'	100	06		
	17		DENNISH' 60 18	9106 Pt	Hear	erlin	A- 8	20 Sc	ute	200	O BAN	10.	7D	2/2	7.7	
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	Registr		APR 1 7 2	006 1	as A	*	PAR	9								

			For State Registrar			of Maryla		artmen rtificat				R	eg. No	006	11925
	Physici	an	1. Decedent's Name (F									2. Date of Deat Month	Day	Year	3. Time of Death
,	/Medic	al	Ruth 4a. Facility Name (If no			Pierson		4h City	Town or	Location of	of Death	April	9,	2006 unty of Death	7:43 p ^M
	Examin	er	Edenwald	t institution,	give street and	number)		40. City,		wson	oi Deatti			Baltimo	
	Funeral		5. Social Security Num	ber	6. Sex		s. last birthday)	If Under	1 Year	If Under		8. Date of Birth (Month, Day,	V1	9. Birth	place (State or Foreign
	Director		216-12-394	8	1 □ M 2 💢 F	8	3 Yrs.	Months	Days	Hours	Min.	July 23	, 192	22 Mar	yland
7	p ,		Usual Residence of De	cedent b. County		100.0	City, Town or Lo	ocation							10d. Inside City Limits
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	the N	Director	10e. Street and Number		- Inot C		100	10f. Zip	Code			1	0a. Citizer	of What Cou	
	with	<u></u>	800 South		Road #20	13			212	86			Ţ	ISA	,
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3	within 72 hours after death with the Maryland ene. Han "naturel", or items 23a or 28a-f show ha Madical Esteriiner mail ke rudified al	d by	3		Year	or Dates:								^{pecify:} whit	
Maryland 21215-0036	"nati	Completed	15 (Specify	. Decedent' on <i>ly highest</i>	s Education grade complete	ed)	16a. Dece (Give	dent's Usua kind of wo DO NOT u	rk done d	during mos	t of work	ing	16b. Kind	of Business/Ir	ndustry
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0	filed Hygi other	BeC	17. Father's Name (Fir	st, Middle, L		<u> </u>	· ·	HOME	llake		er's Name	e (First, Middle, I			
ä	lid be lental rked iic ev	To B	Clarance	e Herr	,					M	lary	Tracy			
a _Z	should had had had had had had had had had ha	-	19a. Informant's Name	Alationsh	ip (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Run	al Route Number	City or To	own, State, Zi	p Code)
Σ	and 2 ealth n 27 i		Judy Exde		ughter	1	9 A11	cway (Circ	le To	wson	MD 21	286		
baitimore,	Fiter or of H		20a. Method of Dispos		3 Removal fr		Place of Dispo cemetery, cre	nsition (Nar matory or c	ne of other plac	e)	ı	Date	20c. Local	ion - City or T	own, State
	tment tent:		`4 ∑Donation 5			1									
a D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Hygiene. Department of Health and Hygiene. Department of Health And Hygiene. Department of Health And Hygiene.		21. Signature of Funer RO1	nald S	icensee	Directo		2. Name ar tate				655 W.	Balt	imore !	Street
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٥.			shoo, r heart fa	ailure. List o	only one cause of	on each line.		1	10						Interval Between Onset and Death
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	Examiner				· .	to (or as a conse	wrate	~	mi	2720	cié	m			Imo.
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Vital Records, P	The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as the		Part II. Other significa	int conditio	ns contributing t	o death but not re	esulting in the t	inderlying o	ause give	en in Part I	l. ———		oacco use es 2 🗆 1	_	the cause of death? bably 4 Unknown
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ī	yeicien: The l is certificate ha director, page	Be (25. Was case referred examiner?	to medical							e of Deat	h (Check only or	e)		-0-
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	Jing After fune	io	21	5 Pending	9	ate of Injury Month, Day Year)	Injury	м '	28c. Injun Worl 1 □	k? Yes 2□	No	Zuu. Describe in	ow injury o	Courred	
DIVISION	l or Attending after death. Director; After in by the funer	fical	0 0 - 0.0.00	6 Could n	ot be 28e, P	lace of Injury - At	home, farm, st	reet, factor						lumber or Rui	al Route Number,
2	in Signal	Certification:	4 🗌 Homicide	4	b	uilding, etc. (Spe	city)					City or Town	n, State)		
	To the Hospitel or Attenwithin 24 hours after deating the Funerel Director; completely filled in by the	edlcai C	29a. Certifier (Check only one)	Certifying Medical E	Examiner: On th	the best of my k ne basis of exami nanner stated.	- nowledge, deal nation and/or in	th occurred evestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the c red at the time, d	ause(s) an ate and pl	d manner as a	stated. to the cause(s)
	To th within To th	Me	29b. Signature and titl	e of certifier		,		29	c. Licens	e number		2	9d. Date s	igned (Month	(Day, Year)
			Y	$II\Lambda$	^~~	ph	allon			29	フ	69	4	1001	06-1
		1	30. N and address	of person	who completed	cause of death	em 23a) (Type	Print)	· ·	(6 a	. 6	11.	41	0	1. and
		111	marriel	in	1)c /	Move	nne	ry	5	160	1 R	ling.	14	Bul	se ax
	Sta Regist		31. Date filed (Month)	Day, Year)	2006	2. Registrar's Sig	S ASS	a Cardon				V			

			1 - For State C	•	artment of Health and rtificate of Death		ene) 06	11926
	ಿ೦		Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		MARY LOUISE SAN	DERS		April 1	L5, 2006	5:00 P. M
	Examin		4a. Fecility Name (If not institution, give street and no		4b. City, Town, or Location of Deal	th	4c. County of Death	
			Manor Care Ruxton	T	Towson		Baltimo:	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 1 F	7. Age (In yrs. last birthday) 97 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	(Month, Day, Y	'ear) Cou	place (State or Foreign ntry) yland
-			Usual Residence of Decedent	31		Dec. 16,	1908 Mar	yranu
	rylan		10a. State 10b. County	10c. City, Town or Lo	cation			Od. Inside City Limits
	8a-f s	Directo	Maryland Baltimore	Cockey				1 ☐ Yes 2 XNo
	with th	Dire	100.10 C		10f. Zip Code	100	g. Citizen of What Cou	ntry?
	eath i	Funeral	10919 Gateview Road 11. Marital Status 12. Was Dec	cedent Ever in U.S. 13.1	21030 Was Decedent of Hispanic Origin? (5	Specify Yes or No-	U.S.A.	can Indian
0	r Itan	Fun	Armed F 1 □ Never Married 2 □ Married 1 □ Yes	2 🕅 No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White,	
<u> </u>	ral', o	i by	3 XWidowed 4 ☐ Divorced If Yes, G Year or I	Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whi	te
ק	be filed within 72 hours after death with the Marylar tal Hygiene. d othar than "natural", or Itams 23a or 28a-f show evant, the Medical Examiner mat be mulified at	Completed	15. Decedent's Education (Specify only highest grade completed)) (Give	dent's Usual Occupation kind of work done during most of wo	rking 16	6b. Kind of Business/Ir	dustry
[2]	within ane. than	dmo	Elementary/Secondary (0-12) College 4 Ve3	(1-4or 5+)	oo NOT use retired) entary School Tea	chor	Educatio	an.
2	filed Hygie othar	o Co	17. Father's Name (First, Middle, Last)	als Eleme		me (First, Middle, Ma		011
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Examiner nata be multified at	To Be	Daniel Stouff	fer	Emma	Мс	Cubbin	
a Z	shou and M s mar	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or R			Code)
	and 2 ealth a n 27 ls		Elizabeth S. Murray (ste					
ore	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from	20b. Place of Dispo cemetery, crer	sition (Name of matory or other place)	Date 20	c. Location - City or T	own, State
Ě	Pages Iment of I tant: If it jury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Loudon Pa	ark Cemetery 4-1		altimore,	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of Funeral Service Licensee	27	Name and Address of Facility Mitchell-Wiedefel 5500 York Road F	d Funeral	Home, Inc	1212
ī			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not ent				Approximate Interval Between
U	Pnysician				GESTIVE A	nd Isc	HEMIL	Onset and Death
	/Medical Examiner				GESTIVE A		110000	7-530
	Lxammer	<u>.</u>	Sequentially list conditions b. Due to	ARDIO 179	OPATHY			Weeks
7	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	(or as a consequence or).				
	execu al-tra	xar	that initiated events c.	(or as a consequence of):				
8760	ate be executed physician and the burial-transit	dical	d					
٥	rtifical ng phy as th	Aedi	IF FEMALE.					
ROX	death certific e attending p ed for use as	Physician/Me	23b. Was decedent pregnant	utcome of pregnancy birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
о п	0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown		Other (specify)		WOTH	Day 18a1
٦.	The law requires that the de tie has been signed by the a bage 2 should be detached f	Ph)	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I	23e. Did toba	cco use contribute to t	he cause of death?
ds,	signe d be	d by				1 ☐ Yes	2 □No 3 □ Prol	pably 4 Unknown
Sor	w require been sig should b	Completed				24a. Was an	24b. Were auto	psy findings available
ĕ	The law ate has page 2	ошо				autopsy performe	prior to co	mpletion of cause of
r		e e	25. Was case referred to medical		26. Place of De	ath (Check only one)	No 1 ☐ Yes	2 L No
tal H	icia Ser ecl	Ω	examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ER/Outpatien	Othon		ce 6 ☐Other (Specia	(v)
	ys Si Si	0						y)
	ng Physician: ter this certificaneral director, p	!- :	27. Manner of Death 28a. Date	e of Injury 28b. Time of nth, Day Year) Injury	28c. Injury at Work?	28d. Describe how	inquiry occurred	y)
	landing Physeath. or: After this the funeral dir	!- :	27. Manner of Death 1 Natural 2 Accident investigation investigation	nth, Day Year) Injury	Work? M 1 □ Yes 2 □ No			
	ttanding Physdeath. Stor: After this the funeral di	!- :	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be 28e. Place	se of Injury - At home, farm, str ding, etc. (Specify)	M 1 Yes 2 No		et and Number or Run	
	ttanding Physdeath. Stor: After this the funeral di	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date (Mo.	nth, Day Year) Injury ee of Injury - At home, farm, str ding, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
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	d is	!- :	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date (Mo. 1) 5 Pending investigation 6 Could not be determined 28e. Place determined 29a. Certifler (Check only Check on Check on Check on Check on Check on Check on Check	nth, Day Year) Injury se of Injury - At home, farm, str ding, etc. (Specify) ne best of my knowledge, deatt basis of examination and/or in	M 1 Yes 2 No eet, factory, office n occurred at the time, date and place vestigation, in my opinion, death occurred at the time of the control of the control occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation in the control of th	28f. Location (Stre City or Town, e, and due to the cau urred at the time, date	et and Number or Run State) se(s) and manner as s a and place, and due t I. Date signed (Month,	al Route Number, tated. the cause(s) Day, Year)
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Division of Vital Records,	To the Hospital or Attanding Physical Distriction of the Property of the Funeral Director: After this completely filled in by the funeral director of	Medical Certification: T	27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 28e. Place determined 2	nth, Day Year) Injury the of Injury - At home, farm, stricting, etc. (Specify) the best of my knowledge, death basis of examination and/or inner stated. Second	M 1 Yes 2 No eet, factory, office n occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date and place vestigation at the time, da	28f. Location (Stre City or Town, e, and due to the cau urred at the time, date	et and Number or Run State) se(s) and manner as s a and place, and due to	al Route Number, tated. the cause(s) Day, Year)
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		,	For State Registrar	State of M	laryland / Depa	artment of rtificate of		, ,	jiene eg. No. 0 0 6	11927
	Physici /Medic		1. Decedent's Name (First, Middle,	Last) . S	TURDE	VANT		2. Date of Dea Month APRIL	th Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, PLEASANT VIE	give street and number	- HOME		or Location of Dea	th	4c. County of De	
	Funeral Director		215-22-2218		ge (<i>In yrs. last birthday</i>) 79 Yrs.	If Under 1 Yea Months Days			9. B 1926 Mc	irthplace (State or Foreign Country)
	show	J.	Usual Residence of Decedent 10a. State 10b. County Md Carrol	1	10c. City, Town or Lo Sykesv					10d. Inside City Limits 1 Tyes 2 No
	with the N c or 28a-f be rollfi	Direct	10e. Street and Number 711 Lee Avenue			10f. Zip Code 21784			Og. Citizen of What (
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23c or 28a-f show any injury or other treumatic event, the Medical Evantral must be routlised at ODGe.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces VTYes 2 1 HYes, Give Year or Dates:	? No	Was Decedent of If Yes, specify Cu	ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh Specify: W	
21215-0036	within 72 hou ene. than "nature he Medicel E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)		(Give	dent's Usual Occu kind of work done DO NOT use retire aftsman	pation e during most of wo ed)	prking	16b. Kind of Busines Dietrich	
Maryland 2	ild be filed fental Hygi rked other lic event, I	To Be Co	17. Father's Name (First, Middle, L Frank Pierce				18. Mother's Na Ethel V	ume (First, Middle, Madde)	Maiden Sumame)	
, Mary	and 2 shou alth and M 27 is mai		19a. Informant's Name/Relationsh William Gardner						r, City or Town, State Md 21784	Zip Code)
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 14 □ Donation 5 □ Other (Sp		Woodlawn	natory or other pl Cemeter	y 4-19	9-06	20c.Location-City o Baltimore,	Md
Balt	permit. Depart Import any inj		21. Signature of Funeral Service L	t Herber				aight Fun sville, M	eral Home d 21784	& Chapel
	Pnysician /Medical Examiner	_ n	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to for as	id the death. Do not entine. YOCARDIT s a consequence of): PERTEN	tl Inf			est,	Approximate Interval Between Onset and Death
8760, <	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to intri-adiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	s a consequence of):					
P.O. Box 68	ath certific ttending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnan	cy		23d. Date of d Month	elivery Day Year
	uires that the de signed by the a d be detached f	by	Part II. Other significant condition Park	s contributing to death	_	nderlying cause g	iven in Part I.	23e. Did tol		to the cause of death? Probably 4 Unknown
Recol	he law requir	Completed	DEM OSTEO AR	ENTIA				24a. Was a autops perfori	rned death	
Vital	certifica rector, p	To Be Co	25. Was case referred to medical examiner?	Hospital	ient 2⊡ER/Outpatie	nt 3 DOA		ath (Check only on	2 Mo 1 Ye ne) ence 6 □Other (Sp	
Division of Vital Records,	To the Hospitel or Attending Phys within 24 hours after death To the Funerel Director: After this completely filled in by the funeral di	Certification: T	27. Many for of Death 1 V Natural 2 Accident 3 Suicide 4 Homicide 2 Pending investigation investigation determine	ot be 28e. Place of Ir	ury 28b. Time o Injury ay Year) 28b. Time o Injury tijury - At home, farm, strate. (Specify)	f 28c. Inju W M 1 [ury at ork? □ Yes 2 □ No	28d. Describe ho	ow injury occurred	
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis and manner s	of examination and/or in	h occurred at the vestigation, in my	time, date and plac opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 7		29b. Signature and title of certifier	legai	>	29c. Licer	30469	j	9d. Date signed (Mon	nth, Day, Year) 2006
-	5		30. Name and address of person w	to completed cause of	death (Item 23a) (Type,	Print) Print)	+ Swit 30	8, colu	mbiq. Mp	. 21045.
	Sta Registr MH 17 Rev 1/2	te ar	31. Date filed (Month, Day, Year) APR 1 7	32. Regist	rar's Signature					

ORIGINAL

		Please 1 - For State Registrar	State of M		d / Depa		t of H	ealth and N	•		enn	le. 6	1928
Physic /Med		Decedent's Name (First, Middle, La Samuel Henry Sh	river, Jr						2. Date of E Month April			'ear	3. Time of Death 4:42 p M
Exam	iner	4a. Facility Name (If not institution, given 14524 Dover Rd.				G	lynd			4	c. County of Bal	Death Ltimo:	
Funera Directo			Sex 7. Ag 1 M 2 □ F	ge (In yrs. Ia 74	Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of B Month, D July	lirth Day, Year 14, 1	931	Mary	e (State or Foreign Land
C L L I 3-UU30 Itied within 72 hours after death with the Maryland Hygiene. Ither then "nature!", or items 23a or 28a-1 ehow ent, tre Medical Evand at must be notified at	rector	10a. State 10b. County Maryland Baltin 10e. Street and Number	nore		Town or Lo		Code			10a C	itizen of Wh		Inside City Limits 1 ☐ Yes 2 🛣 No
death with ms 23a or	by Funeral Director	14524 Dover Rd.	12. Was Decedent	Ever in U.S	i. 13. V		210		ecify Yes or N		U.S.	Α.	
Ours after of the Eventor	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces: 1 ☐ Yes 2] ☐ If Yes, Give Year or Dates:			Yes, sp <i>ec</i>		spanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)			White, etc. Whit	
C I 3-U	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)				ition Juring most of work)	king		Kind of Busin		•
Maryland 21215-UU36 nd 2 should be filed within 72 hours at lith and Mental Hygiene. 271e marked other then "nature!, or rtraumatic event, tre Meulical Evail.	Be Con	12 17. Father's Name (First, Middle, Last	6		rinai	ncial	PLa	nner 18. Mother's Nam	e (First, Middl		nriver	and	Co.
E should to and Ment to marke aumatic	2	Samuel H. Shri		_	19b. Mailin	g Address	(Street a	Eleano			or Town, Sta	ate, Zip Co	ode)
DEILLINOTE, METYIERG Z IZ IS-UUSO permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "naturel", or items 23a or 28a-f show any Injury or other traumatic event, tra Madical Examination must be notified at		Margot K. Shriver 20a. Method of Disposition 1 Burial 2 XCremation 3 4 Donation 5 Other (Special	Removal from State	20b. Pla	14524 use of Dispos metery, crem ro Cre	sition (Nam natory or ot	ne of ther place	Glyndor April 17,	Date	20c. L	1 Location - Cit		
permit. I Departm Importal any Inju		21. Signature of Fyneral Service Lice	**		22 Ec	Name and	Addres	s of Facility uneral Ch terstown	napel P	- A -	Let an area		
Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cause one cause on each line. Due to (or as	6 4	Do not ente	er the mode	of dying		or respiratory			Ap	oproximate terval Between nset and Death
e be executed sician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.										
the d	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetel d	leath 3	Ectopic pre Other (spe					23d. Date o Month		y Year
quires that n signed by	d by Ph	Part II. Other significant conditions of	contributing to death b	out not result	ing in the un	derlying ca	use give	n in Part I.			use contribu		ause of death?
	Complete	CURENIC							24a. Was auto perf 1 Yes		dea	re autopsy r to comple th? Yes 2	findings available etion of cause of
alcian certif rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of Death	10				
Attending Physician: r death. ector: After this certific	tlon: To	1 Yes 2 Yolo 27. Manner of Death 1 Watural 5 Pending 2 Accident investigation	1 ∐ Inpatie 28a. Date of Inju (Month, Da	iry 2	R/Outpatient 8b. Time of Injury		Bc. Injury Work	4 🗆 Nursing no	me 5 2 fes 28d. Describe			Specify)	
i Site	Certification:	3 Suicide 6 Could not b	e Diese of lei	jury - At hom c. (Specify)	ie, farm, stre				28f. Location City or To			or Rural Ro	oute Number,
4 4 7 9 9	edical C	29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best niner: On the basis of and manner sta	r examinatio	edge, death on and/or inve	occurred a estigation,	t the time in my op	e, date and place, inion, death occurr	and due to the ed at the time,	cause(s , date and) and manne d place, and	er as stated due to the	d. e cause(s)
To the I within 2 To the I complet	W	29b. Signature and title of certifier	MP			29c.	License	number 92773 u		29d. Da	te signed (A	OC C	r, Year)
OT		30. Name and address of person who	completed cause of d	A	23a) (Type, F	Print)		JT.		TIM	ore	14	9 2120
St Regist	ate	31. Date filed (Month, Day, Year) APR 1 7 21	32 Registr	ar's Signatu	re Ave	de					,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 11:13 P. 14,2006 Anna Mae Tolson APRIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Arunde Baltimore Washington Center Glen Medical If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 21, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Hours Days Min. 82 MD Yrs. Nov 212-20-3072 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other treumatic event, the Medical Examiner must be notified at 1 □Yes 2√No Director Pasadena MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21122 USA 758 209th St or iteme 23a 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural; or item eny injury or other treumatic event, the Medical Evantment ODG. Black, White, etc. 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Tolson, Anna Mac Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Š 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Financial 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alice Townsend Richard Tilden Baxter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7975 Crain Hwy #223, Glen Burnie, MD John Simmons Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-19-06 Glen Haven Cemetery Glen Burnie, MD 4 □Donation 5 □Other (Specify) Funeral Service Licensee Fink M01148 Fink Funeral Home, P.A.

Gregory Fink M01148 426 Crain Hwy SW, Glen Burni

Enter the dispesse, or samplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 426 Crain Hwy SW, Glen Burnie, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EMPHYSEMA Pnysician /Medical Due to (or as a consequence of) Examiner DNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and is the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as I for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 20nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate the Hospital or Attending Physician: hin 24 hours efter deeth. the Funerel Director; After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 ☑ No 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00055973 M.S. APRIL 14,2006 kassehin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spring way GIVER Sutherland hi11 11500 Desse 3 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar		Се	rtificate of l	Death	R	eg. No:	Jb	11930
	Physici /Medic		Decedent's Name (First, Middle, L		C. Thompso	on		2. Date of Deal	Day	Year OOG	3. Time of Death 7:10 A M
1	Examin		4a. Facility Name (If not institution, g				Location of Death		4c. County	of Death	
			GOOD SAMARIT		DITAL		-IMORE				
	- Funeral Director		5. Social Security Number 6. 215-30-3323 Usual Residence of Decedent	Sex 1□M 2AF	ge (In yrs. last birthday 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3-22-	1932	9. Birthpla Count	ace (State or Foreign ry) Md
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
	Many a-f sh	tor	CA		San Diego)					1 ☐ Yes 2 No
	th the or 284	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Count	ry?
	ath wi	rai	3319 Laurelridge	Road		9212	.0		U S	A	
21215-0036	is 1 and 2 should be filled within 72 hours after death with the Maryland of Heelth and Mental Hygiane. Item 27 is marked other than "naturel", or Iteme 23s or 28s-f show other traumatic event, the Medical Exercitor Lister by routilised at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Armed Forces? 1 Yes 24 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes X No	ispanic Origin? (Spe n, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, e y: B1a	tc.
200	72 ho	ted	15. Decedent's I (Specify only highest g	mda somelated)	10 in	edent's Usual Occupa	ation		16b. Kind of B	usiness/Ind	ustry N/A
21	within sene.	Completed	Elementary/Secondary (0-12) IIth grade	College (1-4or	5+) life.	b kind of work done of DO NOT use retired)	ng			
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Maryland	ntal hed of	Be	17. Father's Name (First, Middle, Las James Contee	ii.)			18. Mother's Name Corrine J		walden Suman	ne)	
Ž	2 should be f and Mental h is marked ot sumatic ever	<u>L</u>	19a. Informant's Name/Relationship	(Type, Print)	19h Mail	ing Address (Street a			City or Town	State Zin I	Codel
S	and 2 seeth ar n 27 is		Gerard Powell - 9			9 Laurelr					92120
ē,	es 1 and 3 of Heelth f Item 27 r other tr		20a. Method of Disposition		20b. Place of Disp		D		20c. Location		
Ë	Page nent o nt: #		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			rematory		-2006	Catonsv	ille,	Md
Baltimore,	permit. Page Department o Important: If eny injury or once.		21. Signatury 1 Funeral Service Lice	ensee	914	2. Name and Addres	ash Avenu	ch F/H	West to, Md	21215	
Ç :	Fag.		23a. Part1. Enter the disease, or constitution, or heart failure. List only	nplications that cause	d the death. Do not en				est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-2	EP515						Onset and Death
	/Medical		resulting in death)		a consequence of):						
	Examiner		Sequentially list conditions	b. P.	NEUMON	IR					
	p tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	e be executed /sicien and e burial-transit	каш	that initiated events resulting in death) Last	c. UR	a consequence of):	RACT 1	NPECTI	U _\.			
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687	physics the last	dici		d. 197	DIOMYO	PACHY					
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	es thet igned by		Part II. Other significent conditions	contributing to death b	out not resulting in the o	inderlying cause give	en in Part I.	23e. Did tob	acco use cont	ribute to the	cause of death?
of Vital Records,	quires n sign	Completed by	COROBROVAS	CULAR	ACC(DE	NT.		1 □ Y€	s 2 19 No	3 🗆 Proba	biy 4 □Unknown
Ö	law requir as been s 2 should	lete						24a. Was a	n 24b.	Were autop	sy findings available
Re	The la	E O						autops	ned?	death?	sy findings available pletion of cause of
ta	icien: Th certificate rector, pag	4	25. Was case referred to medical				26. Place of Death			1 ☐ Yes 2	: L NO
f V	S D	To B	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Othe				er (Specify)	
0 0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	of 28c, Injury Work	at 2	8d. Describe ho	w injury occur	red	
sio		cati	2 Accident investigate 3 Suicide 6 Could not				fes 2 □No				
Division	frer frer in b	Certification;	4 Homicide determine	289. Place of Inj	ury - At home, farm, st c. (Specify)	reet, factory, office	2	28f. Location (St. City or Town	reet and Numb i, State)	oer or Rural	Route Number,
	pital ours a erel [29a, Certifier 1 Certifying P	hypicing. To the heat	of my knowledge, deep	h					
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination and/or in	in occurred at the time ivestigation, in my op	oinion, death occurre	and due to the ca	ause(s) and ma ate and place,	and due to	ted. the cause(s)
	To the within Fo the Complex c	Me	29b. Signature and title of certifier			29c. License	number	25	9d. Date signe	d (Month, D	ay, Year)
			1 / Ac			200	62239	7 /	APRIL	13 6	2006
	29		30. Name and address of person who	completed cause of c	leath (Item 23a) (Type	Print) DR M	AU NA	1240	s. MD		
7	5 '			600D SI	AMARITA	m, Hos	PITAL,	BAL	21000.	Red	
7.	Sta Registr	te ar	29b. Signature and title of certifier 30. Name and address of person who 31. Date filed (Month, Day, Year) APR 1 5	2006 32 Aegistr	ar's Signature	340					

Registrar DHMH 17 Rev 1/2001

THOMPSON, VIUIAN

			1- For Amend Item 8 State of Maryland / Department of Health and M per FH, G859, 09/13/06dhb per FH, G859, 09/13/06dhb	Mental Hygier	ne 0 0 6	93				
	Physicia /Medic Examin		Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death				
			Francis R. Valeo	Month E	Day Year 9 2006	8:38AM				
			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	ith				
			4550 North Park Ave, Apt. T201 Chery Chase			mery				
	Funeral Director		5. Social Security Number 6. Sex 124 Age (In yrs. last birthday) 124 F 7. Age (In yrs. last birthday) 14	8. Date of Birth (Month, Day, Yea		thplace (State or Foreign ountry)				
			Usual Residence of Decedent	01/30/191	6 Ne	NYOKK				
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do other then "netural; or items 23a or 28a-f show event, the Medical Examinar must be notified at	ctor	mb montgomery Chevy Chase			1X Yes 2 □ No				
		Olre	10e. Street and Number		Citizen of What C	ountry?				
		ral	4550 North Park Ave. Apt. Taol 20815		SA					
	itam Itam	Completed by Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi					
936	al', or		1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes, Give 1 Yes or Dates: 1943-1946 1 Yes 2 No Specify:		Specify:	hite.				
5-0036	2 ho		15. Decedent's Education 16a. Decedent's Usual Occupation	. 16b.	. Kind of Business	Vindustry				
2121	thin 7		(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)		100					
	filed w Hygier Sther th		5+ Secretary of the Senat		litics					
and and	& da ta & •	Be	The state of the s	e (First, Middle, Maid - -	len Sumame)					
Maryland	2 should and Mer is marke sumatic	To	Tames C. Valeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	aleo	T 0					
N N			19a. Informant's Name/Relationship (Type, Print) Leslie Valeo/Daughter-In-law 10685auth Bonneville D							
ē,	s 1 and 1 f Health Itam 27 other tr	- 3	20a Method of Disposition 20b. Place of Disposition (Name of		Location - City or					
altimore,	Page: ient o nt: If ry or		1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Removal from State Coemetery, crematory or other place) Chesapeake Crematory 4-13	-06 Be	Hsville	MD				
a E	permit. Pages Depertment of the Important: If its any injury or of once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	p Funeral.	+ Crema	tion Services				
m	80 1 60		2 moi358 938 Gist Ave. Silve	erSpring,1	MD 209	0				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.			Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition a. Acute Renal Failure			Onset and Death 10 days				
	/Medical Examiner		Due to (or as a consequence of):			TO days				
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T	Ine law requires thet the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	u lu	cause (Disease or injury Congestive Heart Failure							
v O		Examiner	resulting in death) Last Due to (or as a consequence of):							
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99	ing ph	Med	IF FEMALE:	_						
Rox	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery Month Day Year						
	of the de by the a stached f	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)							
<u>.</u>	signed by									
Sp	law requires as been sign 2 should be	d by		2□No 3□P	robabiy 4 Unknown					
Records,		peted		24a. Was an	24b. Were a	utopsy findings available				
ř	sician: The lav	Comple		autopsy performed?	death?	completion of cause of 2 □ No				
Vital	sician: certifica rector, p	Bec	25. Was case referred to medical examiner?	(Check only one)	10 1016	2 110				
0	Physic this of ral dire	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	me 5 Residence	6 □Other (Spe	city)				
ב	D e e	i.	1 KNatural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how in	jury occurred					
<u>s</u>	death death stor: , the f	Icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	20f Lagation (Ctrast						
	al or Attendir after death. I Director: Af d in by the fu	Certificati	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	8f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the cause	(s) and manner a	s stated.				
	the Hc hin 24 the Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date a	and place, and due	to the cause(s)				
	Tot Tot Com	Σ	29b. Signature and title of certifier 29c. License number	1	Date signed (Mon					
	_		CE/CO 056065	4	10-06					
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D JASIE						
	Sta	te.	Carlos Picake 3530 Wisconsin Ave. 5t, 930 Chevy Chase, M 31. Date filed (Month, Day, Year) 32. Restrar's Signature	CIONER						
	Registr	_	31. Date filed (Month, Day, Year) APR 1 7 2006 32. Restrar's Signature							

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			1 = For State Registrar	State of N	Marylan				ealth a Death	ind M	F	leg. No.	5	119	32	
	Physici	ian	Decedent's Name (First, Middle, Last)							Date of Dea Month	ith Day	Year	3. Time o	of Death		
	/Medi		DAZHTANOV			V	AKH				APRIL OL 2006 1245					
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			JOHNS HOPKINS BAYN	EW MESICA			If I lade	BA.	If Under 2							
	Funeral		5. Social Security Number 6. S 214-73-9746	ex 7 ↑ M 2 F		last birthday) Yrs.	Months		Hours	Min.	8. Date of Birth (Month, Day	, Year)	Cour		_	
	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland of the Heelth and Mental Hyglene. If item 27 is marked other than "natural", or iteme 23a or 28a-1 show a or other traumatic event, the Madical Examiner must be natified at		Usual Residence of Decedent		75			<u></u>			6-30-	-1930	R	Russia		
			10a. State 10b. County		10c. City, Town or Lo			ocation					1	0d. Inside C	City Limits	
		ō	Md Balto			0	3617	1				1 ☐ Yes 2 🌠 No				
		ect	10e. Street and Number			Owings	1	LS p Code	-			10g. Citizen o	of What Cour	ntry?		
		ā	155 Wilgate Roa	d				21117					Russia 14. Race - American Indian,			
		Completed by Funeral Director	11. Marital Status								cify Yes or No-					
		'n	1 Never Married XXMarried	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		10.1	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:			Rican, etc.)	В	Black, White, etc.				
336		by	3 Widowed 4 Divorced									Spec	city: Wh	ite		
21215-0036	2 hou	ted	15. Decedent's Ed	ide completed) (Give i			edent's Usual Occupation e kind of work done during most of work DO NOT use retired)				16b. Kind of	ib. Kind of Business/Industry				
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212	T the	E	N/A	College (1-40	N/A	Fa	Farmer					ODDE)zbekhistan Government			
b	otho	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Sum	ame)			
a	ld be kenta	To B	Dastan Vakhfi						Asiy	e R	lesulov					
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, tha Mas	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Addres	s (Street a	and Numbe	r or Rura	I Route Numbe	r, City or Tou	m, State, Zip	Code)		
	and 2 eeith a m 27 is		Mustafa Kurtoglu	- Friend		10.1	Harry	on Ro	n.1 0	erf mi	s Mills	MA	1117			
ē	T Hee		20a. Method of Disposition	rriend	20b. F	Place of Dispo	sition (Na	ime of			ate	20c. Location		wn, State		
2	ages ant of it: if it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		19	cemetery, crer ing Mei	-	-		_7 _ 2	006	Danda	11sto	ım Ma	1	
Baltimore,	artme orter injur		21. Signature of Huneral Service Licer								ch West		ITTS CO	wii, rio	1	
Ba	permit. Page Department of Importent: If any injury or once.		Vinnan	0 1981	i All							•	MA 21	215		
			4300 Wabash Avenue Balto, Md 21215 73a. Part. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							ate.						
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of Vital Records,	w	Completed									24a. Was a autop: perfor	sy med?	death?	psy findings npietion of c 2 No	available cause of	
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hoenital:	-	_		100		of Death	(Check only or	76)				
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בַ	ding F	Ë	27. Manner of Death 1 ■Natural 5 □ Pending	28a. Date of Ir (Month, I	Day Year)	28b. Time of Injury		28c. injury Work			28d. Describe h	ow injury occ	njury occurred			
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						No	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ed	one) and manner stated.							und place	o, and due ((cause(:				
	To T	Σ	29b. Signature and title of certifier	29c. License number					29d. Date signed (Month, Day, Year)							
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1			30. Name and address of person who	completed cause o	f death (Iten	n 23a) (Type,				6	00 N. W	OFE	STN	EYER	0-140	
-			murek A. M	184 m	D J	oms He	PKIN	is Ho	OSA'TA		BALTIN					
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland			nt of H te of L		d Ment		ene	and the second	119	33
			1. Decedent's Name (First, Middle, L	ast)		······································			-		ate of Death			3. Time o	of Death
	Physici /Medio		Jesse	Lee		h	lrigh	†	Sr.		Month oril 1	Day 12, 200	Year 16	10:	55 M
	Examir		4a. Fecility Name (If not institution, g						Location of De			4c. County			
			Hospice of the	Chesapeak	.e		Li	nthic	um			Anne	e Aru	ındel	
	Funeral		· ·		ge (In yrs. la	ast birthday)	If Unde	r 1 Year Days	If Under 24 h	Hrs. 8. D	ate of Birth Month, Day,	Year)	9. Birth	place (State	or Foreign
	Director		217-52-5255	1(X)M 2□F	5	8 Yrs.	1410111113	Days	110013		ov. 18			MD_	
	D .		Usual Residence of Decedent		100 City	. Town or Lo									
	aryla shov	-	10a. State 10b. County		Toc. City	, TOWITOF LO	Cation							10d. Inside C	ity Limits 5 2 ☑ No
	88-1-88	octo	Maryland Anne A	rundel					Burnie)					200140
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28s-f show avent, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number				10f. Zi	p Code			10	g. Citizen of V		ntry?	
	ath v	rai	109 Water Fount						21061				USA		
	er de	nu	11. Marital Status	12. Was Decedent Armed Forces	?	5. 13. \	Was Dece f Yes, spe	dent of His scify Cubai	spanic Origin? n, Mexican, Pu	? (Specify) uerto Rican	res or No- n, etc.)		e - Ameri k, White,	can Indian, etc.	
36	s aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give	No		1 🗆 Yes	2√ No	Specify:			Specify	. Wh	nite	
Ş	tural En	pe pe	15. Decedent's	Year or Dates:		160 Doon	dont's Lle	al Ossuss	tion			Sh Kind of B			
5	"na	Completed	(Specify only highest g			16a. Deced (Give	kind of w		uring most of	working	'	6b. Kind of Bu	usiness/in	dustry	
7	the che	Ĕ	Elementary/Secondary (0-12)	College (1-4or	5+)			Labor				Г	Retai	٦	
р Б	Hyg Hyg other	Ö	17. Father's Name (First, Middle, Las	st)				Labor	18. Mother's I	Name (Firs	t, Middle, M			.!	
an	d be ental	To Be	John Wright	Sr.					Donna	. K	ramer				
₹	Shoul Theri	F	19a. Informant's Name/Relationship			19b. Mailir	na Addres	s (Street a	nd Number or			City or Town.	State. Zit	Code)	
<u> </u>	Ith ar		Cheryl L. Wright	(wife)			-		ıntain			•			21061
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural; or itsms 23a or 28s-1 show any injury or other traumatic svent, the Madical Examinat must be notified at ance.	- 15	20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Na	me of		riPate		0c. Location -			
20	y or		1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec)	metery, cren y l and				2006		ownsvi	110	Mary	land
₹	artme ortan	1	21. Signature of Funeral Service Lic		That,				s of Facility			Funera			
Ba	permi Depa Impo any Ir			1					ntain R	oad.	Pasade	ena. Mi	211	22	• / (.
		-	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause	d the death	. Do not ent								Approxima	ite
			shock, or heart failure. List on Immediate Cause (Final)	one cause on each	line.									Interval Be Onset and	
}	Physician /Medical		disease or condition resulting in death)	a. Cu	~ 3			ce	レ					5 MO	influs.
	Examiner			Due to (or as	s a consequ	ence or):									
		ē	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying	b. Due to (or as	s coneucu	anda of):									
	uted d ansit	듣	Cause (Disease or injury												
<u> </u>	n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequ	ence of):									
8760,	icate be executed physicien and the burial-transit	dical		d											
9	ifficat g phy as th	ed										315			
Вох	eath certific attending p I for use as	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan		-					23d. Dat	e of delive	ery	
œ.	death e atte d for	cia	in the past 12 months?	1□Live birth 4□Pregnant a			JEctopic p Other (s	regnancy pecify)				Мо	nth	Day	Year
o.	that the de ed by the a detached f	Physician/Me	9 ☐ Unknown	9□ Unknown											
Division of Vital Records, P.	The law requires that the death certificate be executed sie hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death I	but not resu	lting in the ur	nderlying	cause give	n in Part I.	2	23e. Did toba	icco use cont	ribute to t	ne cause of	death?
Ĕ	w require been sig should b	ed								_	1 Yes	2 □ No	3 🗌 Prot	oably 4 🗆	Unknown
8	s bee	ojet								2	24a. Was an	24b. \	Vere auto	psy findings	available
æ	The la	Completed								-	autopsy	ed?	death?	mpletion of	cause of
ā	an: tifice tor, p	0	25. Was case referred to medical						26. Place of f		Yes 21	ALNO I	105	2□ No	
<u>=</u>	Physician: r this certifice ral director, p	To B	examiner? 1 ☐ Yes 2 Ø€No	Hospital:	ent 2 E	R/Outpatien	t 3 🗆 D	OA Othe				ce 6 ⊠Oth	er (Snecit	mp	die
0	g Ph er th		27. Manner of Death	28a. Date of Inj	ury	28b. Time of		28c. Injury Work				injury occurr		Thonk	rise
ō	ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		ay roar,	Injury	М		es 2 □ No					poo	
<u>×</u>	ar de secto by th	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of In	ijury - At hor tc. (Specify)	me, farm, str	eet, facto	y, office			ocation (Stre	et and Numb	er or Rura	al Route Nun	nber,
Ö	s after al Dire ed in by	Certification:		building, o	ic. (Cpoony)						y or 7 out,	Olale)			
	To the Hospital or Attanding Physicien: The law within 24 bours after death. To the Funeral Director Atter this certificate hes completely filled in by the funeral director, page 2		29a. Certifier 15 Certifying (Check only 2 Medical Ex	Physician: To the best	of my know	vledge, death	Occurred	at the tim	e, date and pla	lace, and d	ue to the cau	ise(s) and ma	nner as s	tated.	(a)
	To the H within 24 To the Fi complete	edical	onej	and manner s	tated.	on anwor in	osilyatio	i, iii iiiy Op	minori, death of	recurred at	пе ипе, dat	e and place, a	and due to	Jule cause(>)
	To To To To	Σ	29b. Signature and title of certifier	h	1.0			c. License		_	290	d. Date signed	d (Month,	Day, Year)	_
,				nazr	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			D3	59 50 5	>		part	14	2001	0
	221		30. Name and address of person wh		death (Item	23а) (Туре,	Print) /	1	59 50 5 ve, G	lan	Rus	nie	M	D	
_	21			rkan 3			j lal		04,0		,300			2106	اد
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 7 20	A27	rar's Signati	ure Aces	Se de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, per \$1,000 Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1530 Jamar Rashard Waters Physician 04 00 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A University JAge (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 1,2006 Birthplace (State or Foreign Country)
 MD 5. Social Security Number **Funeral** Days Hours Min 1**2** M 2 ☐ F N/A Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. importent: if item 27 is marked other than "natural", or iteme 23a or 28s-f ehov says injury or other traumatic event, the Medicul Exact inserting the Colifical at ODEs. N/A Baltimore 1 X Yes 2 ☐ No MD **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 2313 Wheatley Drive apt # 203 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status I □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 ☐ X lo Specity: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/AN/AN/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Keisha McGowens James Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 2313 Wheatley Drive Baltimore MD 21207 Keisha McGowens Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MT. Zion Cemetery 4/11/06 Lansdowne MD 4 □ Donation 5 □ Other (Specify) 21. Sign the of Funeral Service Licens 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore MD 21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart faiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hupoxia oue to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physicien and s the burial-transit Due to (o a consequence of): Box 68760 Completed by Physician/Medical ding pl IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, I 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 Yes 2 🗌 No Yes Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 X Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerei Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South 3 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINA

		1 - For State Registrar	State of Mar	yland / Dep	artme	nt of Health and te of Death	d Mental H	ygiene Reg. No	2006	11935
Physici /Medic	al	Decedent's Name (First, Middle, Las Baby Girl Webste Aa. Facility Name (If not institution, give)	r		Ab Cib	y, Town, or Location of Do	2. Date of I	Da	72 1	0 12:27
Examin Funeral	er	Franklin Square 5. Social Security Number 6. Se	Haspital PX 7. Age (1)	In yrs. last birthday	E) If Und	SHALE er 1 Year If Under 24 H	Irs. 8. Date of I	Birth	Battin	Thplace (State or Fore
Director		none 1[Usual Residence of Decedent 10a. State 10b. County	□M 2∏F	Yrs.	Months		in. (Month, 26 Mar 1	Day, Year, 0, 20		aryland
with the Maryland s or 28a-f show Le notified at	rector	MD Baltimore		Dunda11	k	ip Code		10a. Ci	tizen of What C	1 □ Yes 2 ∏ 1
ofter death rriteme 23	/ Funeral Director	8133 Delhaven Roa 11. Marital Status 1∑ Never Married 2□ Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give	er in U.S. 13.	Was Dec	21222 edent of Hispanic Origin? ecrify Cuban, Mexican, Pu	(Specify Yes or I erto Rican, etc.)		USA 14. Race - Am Black, Wh	ierican Indian, ite, etc.
hin 72 hours and number and numbe	Completed by	3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	Year or Dates:	16a. Dece (Give life.	edent's Us	ual Occupation rork done during most of use retired)	working	16b. K	Specify:	white s/Industry
and 212 d be filed with ontat Hygiene ed other the	Be	none 17. Father's Name (First, Middle, Last) Dominic A. Web:	none	none			Name (First, Midd Piekut	nor lle, Maider		
IOFE, MARYIANG 2127 ges 1 and 2 should be filed within tof Health and Mentat Hygiene. If item 27 is marked other then or other traumatic event, the Me	To	19a. Informant's Name/Relationship (7) Franklin Square H 20a. Method of Disposition	ype, Print) Hospital	9000 20b. Place of Disp	Fran	ss (Street and Number or nklin Square	Rural Route Num	Rosed		21237
Baltimore, Ma permit. Pages 1 and 2: Department of Health at Importent: if Item 27 is eny injury or other trat		1 Burial 2 Cremation 3 L 4 Donation 5 DOther (Specify, 21. Signature of Emeral Serve Licens	Removal from State	cemetery, cre	ematory or	other place) and Address of Facility Anatomy Boa				
Physician /Medical		23a. Pant. Enter the disease, or composhock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	fications that caused the	Б	artin	iore, MD 21	201			Approximate Interval Between Onset and Death
be executed ician and purial-transit and	edical Examiner	Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi	опавцивлов об).						
ath cer ttendin or use	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	⊒Ectopic p ⊒ Other (s				23d. Date of de Month	elivery Day Year
wrequires that the despension of the a	by	Part II. Other significant conditions co	ontributing to death but n	not resulting in the t	underlying	cause given in Part I.		tobacco		o the cause of death?
VIIAI RECORY sician: The law requ s certificate has been lirector, page 2 should	Completed						per	is an copsy formed?	prior to death?	utopsy findings availa completion of cause of s 2 \(\sum \) No
DIVISION OF VICAL RECORDS, To the Hospital or Attending Physician: The law requires twithin 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	ation; To Be	27. Manner of Death 1 🖾 Natural 5 🗆 Pending 2 🗀 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time o Injury		0	eath Check only 3 Home 5 Re 28d. Describe	sidence		ecify)
pital or Atta ints after de aral Directo	i Certification;	3 Suicide 4 Homicide Could not be determined	building, etc. (Specify)			City or T	own, State	»)	lural Route Number,
To the Hosl within 24 ho To the Fund completely f	Medical	29a Certifier 1 Conting Phy (Check only one) 2 Medical Examination one) 29b. Signature and fittle of certifier	iner: On the basis of ex and manner stated	amination and/or in	vestigatio	d at the time, date and plan, in my opinion, death of	ce, and due to the coursed at the time	e, date and	d place, and dute signed (Mon	e to the cause(s)
		30. Name and address of person who co	completed cause of death	h (Item 23a) (Type	Print)	Square Dri	VA Pork	Limor	3/13/10 0 Mh	21237
Sta Registra		31. Date filed (Month, Day, Year) APR 1 7 2	32. Pegistrar's	Signature	Bell	June 211	· · · · · ·	11110	91 10.	2,23

			1_ For State	State of Mary	land / Dep	artment of H	lealth and	Mental Hygi	-	11000		
.0-		2	Registrar	- 13	Ce	rtificate of	Death		g. No. U U D	11936		
· · · · · · · · · · · · · · · · · · ·	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death		
	/Medic		Robert Arnold Wa 4a. Facility Name (If not institution, given			4b. City, Town, o	r Location of Des	April	4c. County of Dea			
100	Examir	ıer	Washington Count			1 1	ersto		Wash			
15/4	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday,	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth	9 Bio	thplace-State or Foreign		
	Director		219-46-5888	XM 2□F 58	3 Yrs.	Months Days	Hours Mir	May 11,	1947 Mar	yland		
	pu.		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	onation				10d. Inside City Limits		
	Aanyle Febo	ō	MD Washingt						1Yes			
	the N	Director	10e. Street and Number	John	Hagerst	10f. Zip Code		10	g. Citizen of What Co			
	3a or		14014 Marsh Pik	e		217	42		USA	,		
	deeth	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H		Specify Yes or No-	14. Race - Ame			
9	or its	F.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give		1 ☐ Yes 2 ☑ No		ino Hican, etc.)	Black, Whit			
21215-0036	hours after deeth with the Maryland turet', or Itams 23a or 28a-f show It Frantis africal Le riviliad at	d by	3 ☐ Widowed 4 🂢 Divorced	Year or Dates:					Specify: wh			
5	n 72 n	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	6b. Kind of Business	^{/Industry} unk		
12	fited within Hygiene. ther then "	duo	Elementary/Secondary (0-12)	College (1-4or 5+)		tenance	•/					
D	be filed within 72 hours after deeth with the Marylan ital Hygiene. Id other then "natural", or itams 23a or 28a-f ehow of other then "natural", its Marical Examination at the natified at	BeC	17. Father's Name (First, Middle, Last)	mer III	unk	18. Mother's Na	ame (First, Middle, M	laiden Sumame)			
<u>la</u>	thould be id Mental marked o	To B						Cory Walt	ers			
Maryland	and and sm		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	an <i>d Number</i> or F	Rural Route Number,	City or Town, State, 2	Zip Code)		
	1 and Health tem 27		Avalon Nursing Ho				ike Hage	rstown, M	D 21742			
Baltimore,	Pages 1 ar nent of Hea ant: If itam ary or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	1	Ob. Place of Dispo cemetery, cre	osition (Name of matory or other place	(8)	Date 2	Oc. Location - City or	Town, State		
Ë	tmen tant:		4 ☑ Donation 5 ☐ Other (Special									
Bal	permit. Pages Department of Important: If i any injury or once.		21. Sign ture a Funeral Service Licer Ronald S	Wade Vires		2. Name and Addre: State Ana Baltimore		rd ₁ 655 W.	Baltimore	Street		
			23a. Part1. Enter the disease or com- shock, of heart failure. List onty	plications that caused the one cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardia	ac or respiratory arre	st,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Co	ronar	Y A,	tery	D, S	casc	Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):	. L +		Dis	30000			
	- Adminion	<u>_</u>	Sequentially list conditions,	b. Due to for as a con		struct	ive	-0~5	1 32634			
	nsit	nln	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	003 (0 (0. 83 8 0.0))	non, a						
,	execu n end ial-tra	Examiner	resulting in death) Last	c. Due to (or as a co								
760,	ate be executed hysicien end the burial-transit	cal		d En	d st	age 1	Lidne	y Dis	case			
99		Med	IF FEMALE:					,				
Вох	eath certific attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr		☐Ectopic pregnancy			23d. Date of del			
0.	at the dea by the al	Physician/Med	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death 5[Other (specify)			Month	Day Year		
₽	that the ed by detac		Part If. Other significant conditions of	contributing to death but no	et resulting in the u	indertving cause give	en in Part I	23e. Did toba	acco use contribute to	the cause of death?		
Vital Records,	es De	d by		3		arabitying sauso giri	OTT HTT CATCH.		/	robably 4 ⊟Unknown		
S	w requir been si should	Completed						24a. Was an	24h Ware au	utopsy findings available		
Re	The lav	дшс						autopsy perform	ed? prior to death?	completion of cause of		
tal		a	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2 eath Check only one		2 🗆 No		
\geq	d is	OB	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	nt 3 DOA Oth	or	and the same of th	nce 6 □Other (Spe	cify)		
n of		n: T	27. Manner of Death 1. Natural 5 Pending	28a. Date of fnjury (Month, Day Yea	28b. Time o	f 28c. Injun	y at	28d. Describe how				
Sio	Attending r death.	catlc	2 ☐ Accident investigatio	n			Yes 2 □ No					
Division	al or Attend after death Director: / d in by the f	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of fnjury - building, etc. (S)	At home, farm, st pecify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	iral Route Number,		
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical C	29a. Certifier 1 Certifying Pt (Check only one)	ysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the cau curred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)		
	To the within To the	Me	29b. Signature and title of certifier	3		29c. License	e number	29	d. Date signed (Monti	h. Day, Year)		
	> = 0		> Family	muhun		00	6039	6	04/12/0	, 6		
			30. Name and address of person who		(Item 23a) (Type,		6 01	al of	, , , , ,			
				NUM SHE	三 り	, ,	Hanc	ryotsi	wo.	21740		
	Sta	75.00	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature		5 5		, , , , , , , , , , , , , , , , , , , ,			
100	Registr	aı	APR 1 7	2006 1000	Jed John							

			1 = For State Registrar	State of Marylan		rtment of H tificate of L		-	giene Reg. No.	11116	11937
	Dhysioi	20	1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath Day	/ Year	3. Time of Death
	Physicia /Medic		Paniel		w	ONG		April	117	2006	8:35 A M
	Examin	er	4a. Facility Name (If not institution, giv		1.1	0	Location of Death			County of Death	
			Shady Grove Ad			Kockv If Under 1 Year	If Under 24 Hrs.	9. Date of Bir		lontgon	
	Funeral		5. Social Security Number 6. S		Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent					1-07-	1970	¢ Chi	na
	yland		10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Mar a-f-el	ţor	China Gluang	Dong ZV	ruha	١					1 ☐ Yes 2 No
	r 28g	rec	10e. Street and Number	0 +		10f. Zip Code	1			izen of What Cou	ntry?
	d within 72 hours after death with the Maryland Jiene r then "neturel", or iteme 23a or 28a-f ehow The Madical Examiner must be nutified at	Funeral Director	106 mei Wang	Kd.		1	 A		US	A	
	deal	ner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No)-	14. Race - Ameri Black, White	
٥	or ite	E.	1 Never Married 2 Married	1 ☐ Yes 2 K No If Yes, Give		☐ Yes 2 No	Specify:	, 5101,		Specify: A S	
2-0036	hours after tural', or ite	d by	3 Widowed 4 ADivorced	Year or Dates:						// 3	lan
7	"net	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired;	luring most of work	ring	16b. Ki	ind of Business/Ir	ndustry
7	within 72 ene. then "na he Medic	E D	Elementary/Secondary (0-12)	College (1-4or 5+)		Employ			Im	port Ex	port
א ס	il Hygi other		17. Father's Name (First, Middle, Last		30.1	01.11	18. Mother's Nam	e (First, Middle		·	1
<u>a</u>	e d la b	To Be	Peter B. Wona				Tatiar	a Ch	ien		
<u></u>	and Mer le marke	ř	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a					o Code)
Man	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Lin-Lin Yu-Lin Res	menar/Daughter	14151	Darnesto	IWN RA G	perman	itou	in MD 2	2874
<u>ත</u>	t He de de de de de de de de de de de de de		20a. Method of Disposition	20b. P	tace of Dispos	sition (Name of natory or other place		Date		ocation - City or T	
aitimore,	permit. Pages Department of Importent: If It eny Injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Special			e Cremato		-06	Bel	tsville,	MD
			21. Signature of Funeral Service Lice		22	Name and Addres	s of Facility Ra	OPFUN	eral	andCrer	wating :
ñ	permit. Departimport any in		10 on	ma1358	93	3 Grist AV	e. silvers	pring.p	1020	910	Services
-		_	23a. Part1. Enter the disease, or com	plications that caused the death							Approximate Interval Between
	Physician	-	shock, or heert failure. List only Immediate Cause (Final	().	n	VA					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence		arrythmi	u				Lhours
	Examiner			Ischemic		dio my op	nth a				4 years
Ţ		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):	0	6				
V	outed nd ransit	Examiner	Cause (Disease or injury that initiated events	C.							
ĵ	en ar	EX	resulting in death) Last	Due to (or as a consequence	uence of):						
9/8 8	the death certificate be executed y the attanding physicien and tched for use as the burial-transit	dical	•	d							
٥	ntifica ing pl	Med	IF FEMALE:								
ž R	th ce	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1☐Live birth 2☐Feta		Ectopic pregnancy			1 :	23d. Date of delive Month	ery Day Year
	e des	SICI	1 Yes 2 No	4 Pregnant at time of de 9 Unknown	eath 5	Other (specify)				· · · · · · · · · · · · · · · · · · ·	1001
<u>.</u>		Physician/Me	Part II. Other significant conditions	contributing to death but not rec	ulting in the us	dothing course gue	no in Dort I	23a Did i	obacco	rea contribute to	he cause of death?
က်	signed I	by	Pair II. Other significant conditions	contributing to death but not resi	uiting in the ui	idenying cause give	miniranti.		Yes 2		0.4
Hecords,	The law requires that ate has been signed b bage 2 should be deta	Completed		-				-			
စ္	e 2 s	npl						24a. Was		24b. Were aut prior to co death?	opsy findings available empletion of cause of
								1 ☐ Yes	2 2 -No		2 No
Vital	siclen: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Dea				
ö	Phys this ral dii	<u>1</u>	1 Yes 2 No 27. Manner of Death	1. Inpatient 2U	28b. Time of	. 00 50/1	- Transing Th	ome 5 ☐ Resi 28d. Describe		6 □Other (Speci	(y)
	r Attending Phy ier death. rector: After this i by the funeral o	tion	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	(? res 2 ☐ No	200. Describe	now injui	y occurred	
<u>s</u>	uttendi death. ctor: A y the fu	Ical	3 Suicide 6 Could not b	e Gea Blace of Injury At he	ome farm stre			28f. Location /	Street an	nd Number or Rur	a/ Route Number.
DIVISION	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific tely filled in by the funeral director,	Certification;	4 Homicide determined	building, etc. (Specify	y)	out receive, emec		City or To			
	e Hoepital or 24 hours afte e Funeral Dir etely filled in		29a. Certifier 1 Offitifying Pl	nysician: To the best of my kno	wledge, death	occurred at the tim	e, date and place.	and due to the	cause(s)	and manner as	stated.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Example)	miner: On the basis of examina and manner stated.	tion and/or inv	restigation, in my op	pinion, death occur	red at the time,	date and	place, and due	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certifier	01		29c. License			1	te signed (Month,	
i	,	,	> M. Varby	/ Physician	,	0000	33088		/tp	~il 11'	, 2006
	/		30. Name and address of person who	completed cause of death (Iten	23a) (Type,	Print)					
	ク		Mohit Kasho	Ži.							
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Signa	ture	Carte					
	Registr		APR 1 7	2006	A. A						
DH	MH 17 Rev 1/20	001		-	1.						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar	-	artment of H			giene Reg. No.	0.5	11938
	Physicia	an	1. Decedent's Name (First, Middle, Las	1)	MALL	1. 1. 2.1	1/20	2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic		Joseph		VUI	nittal		April	13 2	cole	11297
	Examin	er	4a. Facility Name (If not institution, give	A 1 1	400	4b. City, Town, or			4c. Count		
			DALHIMURE V.4 5. Social Security Number 6. Se	MediCALC ox 7. Age (In yrs.	last birthday)	If Under 1 Year	MURE If Under 24				lace (State or Foreign
	Funeral Director		218-46-5866	XM 2□F 58	Yrs.	Months Days		Min. (Month, Da March 1	y, Year)	Coun	MD
,			Usual Residence of Decedent					paren 1	0,1340		1110
-	how	_	10a. State 10b. County	10c. C	ty, Town or Lo	cation				1	0d. Inside City Limits
1	8a-1s	cto	MD Baltim	ore	Reis	sterstown					1 ☐ Yes 2X No
1	ueaun win ine maryianu ms 23a or 28a-f show r must be notilied al	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
4	23e	rai	19 E. Cherry Hi				21136	0.40	144.5	USA	
	itan I	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 X Yes 2 No	J.S. 13. Y	f Yes, specify Cubai	spanic Origii n, Mexican, l	n? (Specify Yes or No Puerto Rican, etc.)	Bla	ce - Americ ick, White,	
20	, in	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		I□Yes 2∏ No	Specify:		Specia	<i>ty:</i> B	lack
5	tal Hydiene with 7.2 mous after beath with the maryfat (all Hydiene) of other than "natural", or itama 23a or 28a-f show avent, the Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation		lent's Usual Occupa		of working	16b. Kind of B		
7	Mad .	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done of OO NOT use retired,)	si working			
7	al Hygien other th	Con	12			Tailor			Cloth		
	itai H id oth	Be	17. Father's Name (First, Middle, Last)				18. Mother:	s Name (First, Middle,	Maiden Sumai	me)	
<u> </u>	and Mental and Mental is marked of rsumstic av	J.	Joseph Whittaker	San District	40h 14:35			rtha Edwar			2.11
<u>≅</u>	thank 7 iar traun	1	19a. Informant's Name/Relationship (7 Angel Whittaker		1	-		or Rural Route Numbe t. B Balt			
. ע	ges I and 2 should it of Health and Men If Itam 27 ia marke or other traumatic	-	20a. Method of Disposition	20b.	Place of Dispo	sition (Name of	- 15	Date	20c. Location		
	nent of net: If It int: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	-	natory`or other place		/15/06	77		1 100
	. 문문을		21. Signature of Funeral Service Licen	· · · · · · · · · · · · · · · · · · ·		Cremation . Name and Addres			Reiste	pstea	
Ď	Depa Impo		> Stephen	m. fory	Juny B	line Fune	eral H	ome keist			
	hysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	CA	er the mode of dying	g, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
0000	the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last	Due to (or as a consect c. Due to (or as a consect d.							
O POY O	nie favr equires mar ure dean centro ate has been signed by tha attending p bage 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of (9 ☐ Unknown	aldeath 3□	Ectopic pregnancy				ale of delive	ry Day Year
'n	and det	by P	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to th	e cause of death?
5	is upo		HIV_					_ 101	Yes 2□No	3 Prob	ably 4 □Unknown
נ מ	as be	Completed						24a. Was		prior to con	osy findings available inpletion of cause of
		Con						perfo 1 ☐ Yes	rmed? 2☐₩6	death? 1 🗌 Yes	2□ No
A I CO	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		04-		of Death (Check only o	nne)		
5	this aldir	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 12 mpatient 21	ER/Outpatien		4 🗆 Nurs	ing Home 5 Resid)
5 5	After	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	Work	al ? ∕es 2⊡No		low injury occur	1180	
	aftar deat Director: Jin by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, stro fy)				Street and Num vn, State)	ber or Rura	l Route Number,
41	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 □ Certifying Ph. 2 □ Medical Exam	ysician: To the best of my kn iner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time vestigation, in my op	e, date and pinion, death	place, and due to the occurred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
,	withir To the	M	29b. Signature and title of certifie	NI	,	29c. License A4 417			29d. Date signe APR		
5 1	17		30. Name and address of person who defined the second seco	completed cause of death (Ite	m 23a) (Type,	Nieth C	REENZ	Street 1	Baltin	22 M	3 2006
	Sta	to	31. Date filed (Month, Day, Year)	32 Registrar's Sign							

Amend Item: 1, per M.D. G-854 4/28/06 reb. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per FH, G85404/11/06dhb 27 per dr Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last)

JOSEPH - IGNITUS 2. Date of Death 3. Time of Death **Physician** Year Apri1 8:20 a.M YOUNG 2006 JR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **M** 2□ F Days Hours Yrs Director 62 MD 214-38-0746 Sept. 16, 1943 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show 7 is marked othar than "natural", or Itams 23a or 28a-f shov traumatic event, the Medical Exacta set must be coulfied at MD Yes 2 No N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3319 Dolfield Avenue 21215 USA Funeral or Itams 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: **Black** À Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "any injury or other traumatic evant, the Max Elementary/Secondary (0-12) College (1-4or 5+) Assembler Western Electric 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph I. Young Sr. Alberta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Moore, Sister 5512 Robinwood Avenue, Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 04/08/2006 Lansdown, MD Zion Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Chatman-Harris Funeral Home Leroy Harris per dvr 5240 Reisterstown Rd.Baltimore, MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Kidne /Medical Due to (or as a consequence of): Examiner Hapalitis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of); Examiner burial-transit 210.00 Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ with 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Spine disease errical 2 No 1 Yes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accider 5 Pending injury death. 1 ☐ Yes 2 ☐ No investigation Accident Diractor: 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C PSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number Philosople 4/12/06 Dec 53061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Benjamin Philosophe MD: 29 5. Greene St. Suite 200, Baltimore, MD 21201

Registrar

State

32. Registrar's Signature

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAR Year **3**Ĭ 2006 9:38 RTCHARD ALLEN. Sr. A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 226-36-4755 74 March 31, 1932 North Carolina Usual Residence of Decedent 10b County 10c. City, Town or Location 10d Inside City Limits 1⊠Yes 2 No Maryland Prince George Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 United States 6205 Kildare Ct. 12. Was Decedent Ever in U.S. Amed Forces? 1 ∰Yes 2□No 3/31/67 If Yes, Give Year or Dates: 10/31/74 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 25 Married 1 Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Staff Sargent U.S. Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 Eloise Allen/Spouse 6205 Kildare Ct.; Fort washington, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Comfort Cemetery April 5, 2006 Alexandria, VA. Mt. 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Forestville, MD. 20747 wa 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2X No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 □ No 1 Yes 2 X No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ∏ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 2 ER/Outpatient 3□ DOA 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D57641

29c. License number

29d. Date signed (Month, Day, Year)

april 03,2006

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

Examiner Division of Vital Records, P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be executed burial-transit and attending physicien for use as the buria cate has been signe, page 2 should be certificate has funeral director, After this Japiter v.
A hours after dea...
real Director: After within 24 hours a

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

2

Examiner

Physician/Medicai

δ

Be Completed

Certification: To

29a. Certifier (Check only one) 29b. Signature

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itams 23s or 28s-f show eny injury or other traumatic event, the Medical Examinations that the notified at

Physician

/Medical

Baltimore, Maryland 21215-0036

State Registrar

JAMES R. DUNNE 31. Date filed (Month, Day, Year) APR 03 2006

and title of certifier

nd address of person who completed cause of death (Item 23a) (Type, Print) USN

17-1)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Dav **Physician** ydelotte Month Year E. nes April 2006 12:10 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner and Rehabilitation Cente Berlin Worcester If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Feb. 7, 19 Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Director 217 36 2130 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 77 is marked other than "natural", or Iteme 23s or 28s-f show treumatic event, Ins Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Worcester Maryland Bishopville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 13342 Hatchery Road 21813 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Aydelotte, Agnes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify: 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Hatchery Worker Poultry 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental h Hiram Warren Littleton Cordelia Ann Lathbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an Item 27 is i Gerald Wayne Littleton, Sr. 7768 Gumboro Rd. Pittsville, MD 21856 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any injury or ott 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery April 5,2006 Berlin, MD 21. Signature / Furnal Service Licensee 22. Name and Address of Facility 108 William St. The Burbage Funeral Home Berlin, MD 21811 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tailure 10 **Physician** MOTTE /Medical Due to (or as a consequence of) Examiner Stage 2 heines denenta ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death P.O. F signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š been si 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes of Vital 2 440 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA this To the number of within 24 hours after death.

To the Funerel Director: After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; Division 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) Hospital 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier # # 29c. License number / DE 29d. Date signed (Month, Day, Year) Kustine Aleju, Mo 01-0006795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISTINE GRIFFIN, MO 1209 CUASTAL HIGHLAY FENLICK ISLAND, DE 19949 31. Date liled (Month, Day, Year) State 2006 Registrar

		915	Please Type or Print in Black in State of Maryland / Dep 1- State Registrar Ce		Mental Hygie							
	Physici /Medio		Doedent's Name (First, Middle, Last) DONALD LEROY ANDERSEN			1 2006 7:30 P M						
	Examir	ier	4a. Fecility Name (If not institution, give street and number) 27361 VENARINGHAM LANE	4b. City, Town, or Location of Death CHESTERTOWN	1	4c. County of Death KENT						
	Funeral Director		5. Social Security Number 6. Sex 1 $\overline{\mathbf{M}}$ M 2 \square F 7. Age (In yrs. last birthday, 77 Yrs.		8. Date of Birth (Month, Day, Y	9. Birthplace (State or Foreign Country)						
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits						
	8a-f sl	Director	MD KENT CHESTE			1 ☐ Yes 2 X No						
	and and a		10e. Street and Number 27361 VENARINGHAM LANE	10f. Zip Code 21620		g. Citizen of What Country? JSA						
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Iteme 23a or 28a-f show or other traumatic avent, the Medical Examinar must be notified at	by Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 1 No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE						
215-0	within 72 ho lene. than "natur Tre Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	bb. Kind of Business/Industry								
Maryland 21215-0036	should be filed wind Mental Hygien is marked other thumatic avent, ITE	To Be Cor	17. Father's Name (First, Middle, Last) THORVALD ANDERSEN	EDUCATION aiden Sumame) SS								
, Mary	and 2 shouealth and Mm 27 is mai			City or Town, State, Zip Code)								
Baltimore,	Parit and Indian		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition cemetary, cre	c. Location - City or Town, State								
Balt	permit. Departr Importa		21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620									
×	Physician /Medical Examiner		Due to (or as a consequence of): Sequentially list conditions. b. CONGESTIN	e FIBRILLAT	TON	Interval Between Onset and Death						
68760,	icale be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c	ARTERY DIS	EASE							
O. Box	The law requires that the death certificate that been signed by the attending physoage 2 should be detached for use as the	Physician/Medic		□Ectopic pregnancy □ Other (specify)	•	23d. Date of delivery Month Day Year						
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown						
Vital Records,		e Completed	URINARY PETENTIC		24a. Was an autopsy performed							
Division of Vil	ding Ph After th funeral	To B	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3 DOA Other: 4 Nursing He	th (Check only one) ome 5 X Residence 28d. Describe how	ee 6 Other (Specify) injury occurred						
DIVIS	tal or Attendest s after death al Director: ed in by the	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)						
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatt 2 Madical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)						
	T T T E	Σ	29b. Signature and title of certifier Eric F. Argure M. T.	29c. License number D 350 4 8	29d.	Date signed (Month, Day, Year) 4/3/7,006						
2			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		11112000						
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrate Signature APR 0 4 2006	South	En. E	VI W M 2121)						

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			For State	State of Maryland				ntai Hygier	2006	11913
			State Registrar		Cei	rtificate of		Reg. M	to. U U U	11270
	Physicia	an	Decedent's Name (First, Middle, La.					Date of Death Month arch 30,	2006 Year	3. Time of Death
	/Medic			zabeth Buckler		-				5:55 A M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of Death	
			Prince George's Hosp		ct hirthday	Chever1y If Under 1 Year		. Date of Birth	Prince Georg	se's
	Funeral		5. Social Security Number 6. S 577-28-6850	ex 7. Age (in yrs. ia	Yrs.	Months Days	Hours Min. At	Month, Day, Yes	921 Mary	place (State or Foreign ntry) Land
	Director		Usual Residence of Decedent					0		
	yland low		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	Man Hed	ţo	Maryland Prince G	eorge's Fore	estvill	e				1 ☐ Yes 🏋 🖸 No
	h the	irec	10e. Street and Number			10f. Zip Code		10g. (Citizen of What Cou	intry?
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Examiner must be molifled at	Funeral Directo	8105 Dogwood Lane			20747	7		USA	
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of I	Hispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
9	or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2√√No If Yes, Give		1 ☐ Yes 2 No		, ,	Specify:	White
21215-0036	irel',	d by	3∕⊠ Widowed 4 ☐ Divorced	Year or Dates:				1		
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2	filed within Hygiene. other then "	ပိ	12 17. Father's Name (First, Middle, Last	1			18. Mother's Name (First, Middle, Maid		
and	ntal h	Be c	Francis DeSales				Lucy Matt			
Maryland	should ind Men ind Men in marke	¹	19a. Informant's Name/Relationship (Type Print)	19b. Maili	na Address (Street	t and Number or Rural i	Route Number, Cit	y or Town, State, Zi	ip Code)
Z	d 2 s th an t7 is treu		Thomas J. Buckler J			•	ne Forestvill			
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. Important: If item 27 is marked other than "naturel", or Itema 23a or 28a-f show appring to other traumatic event, Ite Madical Examinar must be notified at ance.		20a. Method of Disposition	20b. PI	ace of Dispo	osition (Name of	Da		Location - City or T	own, State
Baltimore,	Pages nent of int: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 ○ Other (Special	Hemoval from State		matory or other pla		206	Cuitland N	formland
Ħ	artme ortan injury		21. Signature of Juneral Service Lice	nsee / / /	2	Nat. Cemeter 2. Name and Addre	ess of Facility		Suitland, N	
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			23a. Part1. Enter the disease, or com	blications that caused the death					, 10111 201	Approximate Interval Between
	Dharistan		shock, or heart failure. List only Immediate Cause (Final			amatria Car	diamanian D	÷ 00000		Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Hypertensive Art		erotic Car	diovascular D	1sease	-	10 years
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	d d ansit	Examiner	Cause (Disease or injury that initiated events	6						
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89	certificate iding phys se as the	Physician/Medi								
Вох	endir use	N/U	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar		⊒Ectopic pregnanc	cv		23d. Date of deli	*
œ.	death	sicla	in the past 12 months? 1 ☐ Yes 2 ∑N o	4 Pregnant at time of de		Other (specify)			Month	Day Year
P.O.	requires that the een signed by th hould be detache	'n	9 🗆 Unknown		· ·			1		
	gned be de	by	Part II. Other significant conditions	•	ılting in the u	ınderlying cause gi	iven in Part I.			the cause of death?
ord	w require been si should I	ted	Alzheimers Disea	ise				1 Yes	2 X No 3 Pro	obably 4 Unknown
ပ္မ	> D 0	Completed	Upper Gastrointe	stinal Bleeding				24a. Was an autopsy	prior to c	topsy findings available completion of cause of
æ	The law sate has page 2	Š	Cerebrovascular	Accident				performed 1 ☐ Yes 2₹√∑		2 No
ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	Check only one)		
Division of Vital Records,	Physician: this certific ral director,	2	1 ☐ Yes 2.XXNo	Hospital: 1 1 Inpatient 2 1		III. OLI DON			6 ☐Other (Spec	erfy)
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	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification:							-/->	
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	the thin 2 the mplel	Med	one)	and many er stated.		29c. Licen	nse number	29d.	Date signed (Month	n, Day, Year)
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	0 1		Mum		2000	700				
C	(6)		30. Name and address of person who William D. Ros				New Carro	1ton. M	ID 20784	
		100	31. Date filed (Month, Day, Year)				Odilo		20,04	
	Sta	ate	ADD a o one	32. Registrar's Signa	Saul 1	,				

			1 - For State Registrar	State of Ma		Depar		of Heal	th and M	-			11944
	Dharaia		Decedent's Name (First, Middle, Last)							2. Date of Do			3. Time of Death
	Physici /Medi		Mary Cathe		ley					04	01	2004	0344 M
	Examir	ner	4a. Facility Name (If not institution, give si PENINSULA KEGIONAL)		NOVA	ex "	4b. City, Tov	vn, or Loca	tion of Death			WICIMI	
	Funeral	۳	5. Social Security Number 6. Sex		(In yrs. last		If Under 1 Y		nder 24 Hrs.	8. Date of Bi	irth		thplace (State or Foreign
	Director		220-20-0033	M 2XCXF 7	5	Yrs.	Months D	ays Ho	urs Min.	Sept. 1	$\frac{ay, Year)}{1, 9}$	930 1	MD
~1	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Loca	ition						10d. Inside City Limits
-683-	death with the Maryland ims 23a or 28a-f show rmust be notified at	ctor	MD Wicomico)	Salis	sbury							1 X Yes 2 □ No
9	with th	Funeral Director	10e. Street and Number				10f. Zip Co	de 1804				izen of What Co	ountry?
4	leath v	eral	612 Decatur Ave.	2. Was Decedent Ev	ver in U.S.	13. Wa			c Origin? (Spe	city Yes or N	USA •-	14. Race - Ame	encan Indian
222	ĕ ₹ ₹	by	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		-	es, specify Yes 21X		c Origin? (Spe xican, Puerto ecify:	Rican, etc.)		Black, Whit	e, etc.
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/an	2 sho 2 sho is ma rauma		19a. Informant's Name/Relationship (Typ	oe, Print)								r Town, State, 2	Zip Code)
Nary nore, N	of Heelth of Heelth itsm 27		Tom Tull 20a. Method of Disposition			of Dispositi			Salisb	ury, Mo		18U4 ecation - City or	Town, State
\mathcal{M}_{ar} Baltimore,	ages ent of ht: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	tery, crema: ^s i de			4-4-	2006		lin, Md.	
alt:	permit. Pages Department of Important: if i sny injury or once.		21. Signature of Fun, al Service License	96	INTVCI							ineral H	
<u> </u>	8888		While Du	lage					St., B			21811	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	eations that caused the cause on each line	he death. D	o not enter	the mode of	dying, suc	h as cardiac o	r respiratory a	ırr <i>e</i> st,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			RDIAL	- INF	AR (TIO	4			18 HRS
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68	g ph	Pa	IF FEMALE:										
Box	Attanding Physician: The law requires thet the daath certificar death. clost, Alter this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal dea		ctopic pregn				2	23d. Date of del Month	livery Day Year
o.	t the da by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at til 9□Unknown	me or death	5□0	Other (specif	у)					
<u>رة</u>	es thet gned b	by Pt	Part II. Other significant conditions cont		not resulting	g in the unde	erlying cause	e given in F	Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
ord	v require been sig should t	ted	ACUTE RENAL	FAILURE						10	Yes 2	□No 3□Pr	obably 4 Unknown
ec	e law re has be	Completed	CONGESTIVE HE	ART FAI	LURE					24a. Was	oosy /	prior to (utopsy lindings available completion of cause of
<u>a</u>	n: The l licate ha ir. page		GASTRO INTEST	INAL BLE	EDINO	ī				perfe 1 ☐ Yes		death? 1 ☐ Yes	2□ No
Z.	ysician is certifi director	To Be	25. Was case reterred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 🗆 EB/0	Outpatient	3□ DOA	04	Place of Death	· · · · · · · · · · · · · · · · · · ·		6 □Other (Spe	city)
ַס	og Phy ter this		27. Manner of Death	28a. Date of Injury (Month, Day		. Time of Injury		Injury at Work?		28d. Describe			CII y)
Sior	Mtsndin death. ctor: Alt y the fun	catic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				М	1 ☐ Yes	2 □No				
Division of Vital Records, P.O. Box	aftar d I Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc.		farm, street	t, lactory, of	fice	1		(Street and own, State)		ural Route Number,
	To the Hospitel or Atlandi within 24 hours atlar death. To the Funerel Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	icien: To the best of er: On the basis of e and manner state	xamination :	lge, death o and/or inves	ccurred at the	ne time, dai my opinion,	te and place, a , death occurre	and due to the	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
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۶	丁丁		30. Name and address of person who com	mpleted cause of dea	/ 1.	(Type, Pri	Sant	000	Phore	Dirim	\triangle	le class	21001
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	Regist		APR 0 4 200	16 Been	J.K	Apr	The same					<i>(</i> -	

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State of Maryland / Department of Health and Ment	tal Hygiene
Certificate of Death	Sea No.

			For	State of M		d / Depa	artmer	nt of He	ealth a			ene 006	11945
			1 - State Registrar			Cel	πiiicai	e of E	eatn			g. No.	2 Time of Dooth
	Physicia	an	1. Decedent's Name (First, Middle, I								Date of Death Month	Day Year 0, 2006	3. Time of Death 2:22P M
	/Medic Examin	_	4a. Facility Name (If not institution,	ive street and number,)		4b. City.	Town, or	Location of		iai cii J	4c. County of Deatl	
	Examin	eı.	12604 Bridge				Po	tomac				Montgome	
Т	Funeral			. Sex 7. An	ge (In yrs. I	last birthday)	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,		nplace (State or Foreign untry)
	Director		579-58-3592	TOW ZAD	93	Yrs.				S	EPT. 12	, 1912 I	Brazil
1	* =		Usual Residence of Decedent 10a. State 10b. County	<u> </u>	10c. City	y, Town or Lo	cation						10d. Inside City Limits
Many	4 2	tor	Florida Dade		M	iami							1 X Yes 2 No
thought the	or 286	Director	10e. Street and Number				10f. Zi	p Code			10	g. Citizen of What Co	untry?
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90	item and item	Funerai	11. Marital Status	12. Was Decedent	?	.S. 13.	Was Dece If Yes, spe	ident of His scify Cubar	spanic Orig n, Mexican	Puerto Ric	y Yes or No- an, etc.)	Black, White	e, etc.
2 5	rai', or iteme 23a or 28e-f ehow Exeminer must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	7.40		1 🛱 Yes	2□ No	Specify:	Brazi.	T	Specify: WIII	LLC
G E I E I O O O O O O O O O O O O O O O O	natural, or		15. Decedent's (Specify only highest			16a. Dece	dent's Usu	al Occupa	tion uring most	of working	1	6b. Kind of Business/	Industry
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1	ygien ygien t, t		12				- Jean			r's Name /F	irst Middle N	laiden Sumame)	
2 4	od otl	Be	17. Father's Name (First, Middle, La								o Perez		
	mark matic	၉	Manuel Madurei 19a. Informant's Name/Relationshi			19b. Maili	ng Addres	s (Street a				City or Town, State, 2	Zip Code)
	alth an 27 is ritau		Maria A. Sonthe		ce	126	04 B1	idge	ton D	rive,	Poton	nac, MD 208	354
ב ב	permit: rages i end 2 should be lied within 75 no Department of Heelih and Mental Hygiens Importent: if item 27 is marked other then "nature eny injury or other traumatic event, the Medical once.		20a. Method of Disposition	V	20b. P	Place of Disponentery, creacelan	osition (Na matory or	me of other place	a) !	Date		Oc. Location - City or	
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	Departr Departr imports eny inju		21. Signature of Euneral Service Li	censee									l Home, Inc.
9	20.5 2 9		13/100										g, MD 20904
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	ny one cause on each	1/110.			ide of daliti	y, such as	Carciac of fi	espiratory arre	51,	Interval Between Onset and Death
P	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a End Due to (or a		e Deme	ntia						
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00	physics the t			d									
אַ מַ	The law requires that the death certificate ite has been signed by the attending phys age 2 should be detached for use as the	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. Date of de	
ַ בֿ	death d for t	iciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			□Ectopic □ Other (pregnancy specify)				Month	Day Year
2	by the	hys	9 Unknown	9□ Unknown									the series of death?
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ecords,	requil	Completed by	Peripheral	Vascular D	ISCAS	<u> </u>							
) 1	e law hes b	ap de									24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
			OS Was are referred to modified			·	***		36 Place	of Death (1 ☐ Yes 2 Check only on		2 □ No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Attending Physician: The lar reath. r death. ector: Alter this certificate hes by the funeral director, page 2	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 □ Inpa	tient 2	ER/Outpatie	ent 3□ (Oth					Niece's Residence
5	g Phy er this eral d	n; To	27. Manner of Death	28a. Date of In	iurv	28b. Time		28c. Injun Wor				w injury occurred	
	ath. or: Aft	atio	1 Natural 5 Pending 2 Accident investig	ation	, , , ,		М		Yes 2				
NVISION OF	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	280. Place UI	njury - At h etc. <i>(Speci</i>	nome, farm, s ify)	treet, fact	ory, office		28	f. Location (St City or Town	reet and Number or A n, State)	ural Route Number,
ב	ors af		CO. Cartillar 4 M Cartifying	Physician: To the be	et of my kn	owledge dea	th occurre	d at the tin	ne date ar	od place, an	d due to the c	ause(s) and manner a	s stated.
	Hos 24 ho Fun stely f	Medical	29a. Certifier 1 X Certifying (Check only one)	xaminer: On the basis and manner	of examina	ation and/or i	nvestigati	on, in my o	pinion, dea	th occurred	at the time, d	ate and place, and du	e to the cause(s)
	of the	Me	29b. Signature and title of certifier				2	9c. Licens	e number		2	9d. Date signed (Mon	th, Day, Year)
)	7		1 Man	10				0005	5675	2		14/01/2001)
	>		30. Name and address of person v	no completed cause of	f death (Ite	m 23a) (Type	e, Print)	· · · · · · · · · · · · · · · · · · ·				-	
			Naznin Esphan	, MD 32	25 Ve	rona I	rive	, Sil	ver S	Spring	g, MD 2	0906	
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	006 Page	5 JU	ature	and it						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registraramend item #12 per fh 3/28/06 stificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 1053 am HORACE CLIFTON 22 2006 /Medical MARCH 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHESTER HOSPITAL CENTE RTOWN EN7 RIUMR HESTE If Under 24 Hrs. If Under 1 Year Date of Birth Sex 1 M M 2 ☐ F 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-38 Months Days Min Hours -0424 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21678 USA or Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black) Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) la marked other than College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden TON 0 SC 19a. Informan's Name/Relationship (Type, Print) 19b. Mailing Address (Street and ral Route Number, or Town, State, Zip Code) If itam 27 20a. Method of Disposition

1 ABurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, crematory Date 20c. Location - City or Town, State permit. Page:
Depertment o
Important: If
any Injury or
once. Injury or 4 □ Donation 5 □ Other (Specify) lure Tury rail Service Licensee Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or repiratory arrest shad, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician そったとの /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading Limited 20 cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consuluence of Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient PR/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No Director: / 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) ZU Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) S 0037765 200 (1) grate ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and Pate filed Month, Day, Year) 32. Begistrar's Signature State Registrar 8

		For State Registrar	State of Mary		artment of rtificate or		, ,	ene 2.00	6	1947
*	100	Decedent's Name (First, Middle, Last)					2. Date of Death	-	-,,,,,,,	3. Time of Death
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Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town,	, or Location of Deat	h	4c. County	of Death	, J. 15 p
	4	CIVISTA MEDICAL CE 5. Social Security Number 6. Sex		yrs. last birthday)	LA PLAT		0.0	CHARI		
uneral irector			M 2⊠F	56 Yrs.	Months Day		8. Date of Birth (Month, Day,)	1949	Coun	lace (State or Foreign htry) nington D.C
		Usual Residence of Decedent					Dec. 30,	1343	Mazi	ington D.C
23s or 28s-f show	۳.	10a. State 10b. County		c. City, Town or Lo					1	Od. Inside City Limits
28a-f	ecto	Maryland Prince Ge	eorge's	Accoke						1 ☐ Yes 2 💢 No
L Pa	2	10e. Street and Number 15703 Alhambra Cou	int		10f. Zip Code		100	Citizen of V		try?
900	Funeral Director		12. Was Decedent Ever	in U.S. 13.1		0607 Hispanic Origin? (S	pecify Yes or No-	U.S.A	e - Americ	an Indian.
all le	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give			Hispanic Origin? (S iban, Mexican, Puert	o Rican, etc.)	Blac	k, White,	
	d by	3 🖾 Widowed 4 □ Divorced	Year or Dates:		1 ☐ Yes 2 🛣 Ne	o Specify:		Specify	Whi	ite
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	Be C	17. Father's Name (First, Middle, Last)		11010	. 110003	T	ne (First, Middle, Ma			
	To B	Albert Frank Dent				Bettv	Francis Da	avis		
		19a. Informant's Name/Relationship (Typ				et and Number or Ru	ıral Route Number, (ity or Town,		
		Tara M. Saunders/D				Drive, Cha	arlotte Ha	11, Ma	aryla	nd 20622
5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		natory or other pl	(ace) An		c. Location -	City or To	wn, State
dury		4 □ Donation 5 □ Other (Specify)		aryland '						Maryland
any injury or other traumatic avant, the Medical Examinar mones.		21. Six Itule of Puneral Service License	\mathcal{D}_{α} MOOC	000	. Name and Add		3035 01d			
	\dashv	23a. Part1. Enter the disease, or complic	cations that caused the				POB 156,		^T, 1 ^v i	D ZU0U4 Approximate
oion		Immediate Cause (Finaf	e cause on each fine.	1		-	or respiratory arres	•		Interval Between Onset and Death
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	ZW/	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pro					23d. Date	e of delive	rv
	Icla	in the past 12 months? 1 Yes 2 No	1 Live birth 2 1		Ectopic pregnand Other (specify) _	су		Mor		Day Year
	Physician/Me	9 Unknown	9□ Unknown							
8	ò	Part fl. Other significant conditions conf	tributing to death but not	t resulting in the ur	derlying cause g	iven in Part I.				e cause of death?
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							performe 1 ☐ Yes 2 🗷		eath? □ Yes	2 🗆 No
	o Be	25. Was case referred to medical examiner?	ospital:		- 0	M	th Check only one			
5	-	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Usunpatient	2 ER/Outpatient 28b. Time of	00,2011		ome 5 Residence)
in a	ig of	1 ■ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Yea	(r) Injury	28c. Inju Wo M 1 [ork? □Yes 2 □No		,,	, ,	
5	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location (Stree	t and Numbe	or or Aural	Route Number,
	Ser	· Internation	building, etc. (Sp	<i>өспу)</i>			City or Town, S	olale)		
		29a. Certifier 1 Certifying Physic (Check only 2 Medical Examin.	ician: To the best of my er: On the basis of exam	knowledge, death	occurred at the t	ime, date and place,	and due to the caus	e(s) and mar	ner as sta	ited.
completely filled in by the t	Medical		and manner stated.	7						
•		29b. Signature and title of certifie	- of atta	~	29c. Licen	se number	29d.	Date signed		2006
		1 4000	(00,00		D 52	289		7/2	0/.	2000
		30. Name and address of person who con								
) Stat	_	MATHUR, NALTN, MD 31. Date filed (Month, Day, Year)	10 ST PATR 32. Bygistrar's S		JTTE 404	WALDORF,	MD 20603			
Renietra	٠ ا	0PR 0 4 20	00							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) , Day 20<u>06</u> April 2, 9:15 P M **Physician** Elmer Dean Beverly /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Waldorf 1004 Peach Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 28, 19 5, Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Virginia 1939 223-48-1210 Director 66 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maxical Examinar mast be notified at 1 ☐ Yes 2 ☐ No Director Waldorf Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20601 USA 1004 Peach Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 □ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Giant Food Store Grocery Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lula Tyler Forest Beverly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1004 Peach Court, Waldorf, MD 20601 Stephen Beverly 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages
Department of
Important: If It
any injury or o 1 Burial 2 Cremation 3 Removal from State Green Hill Cemetery 4-7-06 Buena Vista, Virginia ' 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 3035 Old Washington Rd. POB 156, Waldorf, MD 20604 <u>Huntt Funeral Home</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreo **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed as the burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has 20 No 1 ☐ Yes 2 ☐ No certificete 1 ☐ Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🛂 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After or Attending Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier icai completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A 581 gistrar's Signatu 31. Date filed (Month, Day, Year) State APR 04 2006 Registrar

06-02	344
Birch,	Mary

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Mary			ite of Marylar	•	of Health and Ment	tal Hygiene)	
		1- For State Registrar		Certificate	of Death		Reg. No. 2	6 1194
Physicia cal Examir	n/	Decedent's Name (First, Middle	,Last)	2		2. Date of Month	Day Year	3. Time of Death 6:30
Cai Exami		4a. Facility Name (if not institution Penninsula Regional M	-	n Birch	4b. City, Town, or Location of Salisbury		5, 2006 4c. County of Do Wicomico	
Summer	=		7	. Age (In yrs, last birthday		r 24Hrs. 8. Date	of Birth (MM/DD/YYYY) 9.	Birthplace (State or Foreig
Funeral Director		231-92-1842	1 M 2 F	89	Yrs. Months Days Hours	Min.	1	Country) Virginia
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation			10d. Inside City Limits
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Z 15-00-50 filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Funeral Director	11 Marital Status	12. Was Dece	ces?	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,			• merican Indian, Black, c.
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Fe, THea Fiter		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from	a mate .	sposition (Name of cemetery, or other place)	Date	20c. Location - City	y or Town, State
Pages Pages nnt: I		4 Donation 5 Other Spe			Comotory	4/8/20	oob Chinto	traque
Dalt permit Departm Imports injury o		21. Signature of Funeral Service L		30.009	Como tory 22. Name and Address of Facility	,		UA 23336
D E S E E		amanda c	- Botto		Salyer Funeral	Home 6	,327 Church &	st. Chincology
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	on each line.		ter the mode of dying, such as ca	ardiac or respirato	ory arrest, shock, or heart	Approximate InterVa Between Onset and Death
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66 / 60 ertificate b ding physi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	I LIVE DII	2 _	Fetal death 3 Ectopic	c pregnancy	Month	Day Year
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VITAI KEC ysician: The l his certificate director, page	Be	25. Was case referred to medical			26.Place of Death	(Check only one)		
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DIVISION tal or Attendi trs after death al Director:	Certification:	3 Suicide 6 Could	d not be 28e. Place		street, factory, office building, et	c. 28f. Loca	ation (Street and Number o fown, State) 1305 Stor r, DE	r Rural Route Number, City ne Boundarv Rd.
DIVI e Hospital or 124 hours afte e Fimeral Dir letely filled in	Cer	4 Homicide		residence				
n 24 l n 24 l te Fin letely		(Crieck Drily	•		occurred at the time, date and pla stigation, in my opinion, death oc			
To the within To the comple	Medical	2	and manner sta		29c License number	Carrott at the tille	29d. Date signed	
	-	29h Signature and title of certifier			ZMC LICERSE DUMBER		zau. Date signen	INIUMIII, Day, I Call

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 ORIGINAL

O.C.M.E.

April 6, 2006

DHMH 17 Rev 1/2001 OCME 10/2003

			1 - For State Registrar	State of N	laryland /		rtment of F		Mental Hygi	ene	06	11950
	- Physic	ian	Decedent's Name (First, Middle						2. Date of Death Month	Day	Year	3. Time of Death
	/Medi	cal	JOHN	HUBERT	BYR	RUM	4. 0: -		MARCH		2006	6.00 AM
	Exami	ner	4a. Facility Name (If not institution ATLANTIC GENER		•		4b. City, Town, or	r Location of De RLIN	ath		ity of Death	· man
	Funeral		5. Social Security Number	6. Sex 7. A	age (In yrs. last I	birthday)	If Under 1 Year	KLIN _If Under 24 H	rs. 8. Date of Birth n. (Month, Day,		9. Birtho	
	Director		239-12-9086	1 ⊠ M 2□F	84	Yrs.	Months Days	Hours M	n. (Month, Day, NOV • 28,	Year) 1921	NOR'	place (State or Foreign htry) TH CAROLINA
	pung *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wa or Lo	ation					
	the Marylar 28a-f ehow	0	,	SSEX	7.							10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	r 28a-	rect	10e. Street and Number	SEA	FK	ANKF	10f. Zip Code		10	g. Citizen o	f What Cour	ntry?
	ith with 23s or	Funeral Director	35930 ZION	CHURCH ROAL)		1994	45		_	JSA	•
	r dea	Iner	11. Marital Status	12. Was Deceder Amed Forces	t Ever in U.S.	13. V	Vas Decedent of H	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)		ace - Americack, White,	
96	s afte	by Fu	1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced	ied IŽŽYes 2.Г	3 No : 1942–46		☐ Yes 2X No	Specify:	,	Spec	.,	IITE
5	iled within 72 hours after death with the Maryland Hygiene. Hygiene. Inter then "natural", or Items 23a or 28a-f ehow ont, the Mudical Examere must be notified at	ed	15. Decedent			a. Deced	ent's Usual Occup	ation	1	6b. Kind of		
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Ž	2 should be fi and Mental H le marked of raumatic ever	ဥ	19a. Informant's Name/Relations		10	9h Mailin	Address (Street	PATR:	Rural Route Number,	LEA		Code
			LENA B. BYRUM/						ILLE, DEL			
9	es 1 and 2 of Health 27 Iltem 27 I		20a. Method of Disposition		20b. Place		sition (Name of atory or other place			Oc. Location		
Ë	Pages ment of thant. If Its ant: If Its		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		₽		EMETERY		2/06	ROXAN	A, DE	LAWARE
Raltimore	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	Beslif h.	M0139		Name and Addres	,	HOME, SELB	YVILLE	E, DE.	19975
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	od the death. Do	o not ente	r the mode of dyin	g, sụch as card	ac or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a. Mu	UTI -	-ox	GANS Z	Melle	RE			Onset and Death
	/Medical Examiner		resulting in deality	Due to (or a	s a consequence	e of):	,					
	* * * * * * * * * * * * * * * * * * *	ē	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence	a ut).						
	cuted nd ransit	Examiner	trial initiated events	c. =								
385	cate be executed physician and the burial-transit	Exi	resulting in death) Last		s a consequence	e of):						
172) - 200 8760	icate b physic the b	Physician/Medical		d		_						
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3-6 B		clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth	2 □Fetal deat at time of death		Ectopic pregnancy Other (specify)				ate of delive lonth	Day Year
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5 0 %	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant condition	ns contributing to death	but not resulting	in the un	derlying cause give	en in Part I.	23e. Did toba	icco use cor	atribute to th	ne cause of death?
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ع کو	e law has b	Completed	Resp. Jus	leen				0	24a. Was an autopsy		prior to cor	psy findings available npletion of cause of
0%C	iician: The la certificate has rector, page 2	S	/ ()						perform 1 Yes 2	ed? XNo	death? 1 ☐ Yes	2 No
- F- 5	s certi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ÎNo	Hospital: 1 Mnpat	ient 2□ER/C	Vitantiont	3☐ DOA Othe	20	eath (Check only one			
500	ding Phys		27. Manner of Death	28a. Date of Inj		. Time of	3 DOA 28c. Injury		Home 5 ☐ Residen 28d. Describe how			/)
5 80	ittending death. stor: After / the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	ay rear)	Injury		res 2 □ No				
S C S	or Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place of in	njury - At home, f etc. (Specify)	farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Num State)	ber or Rura	l Route Number,
á °	pital ours a neral C		29a. Certifier 18 Certifying	Bhusiainn To the best	of multipout and							
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certilicate h completely filled in by the funeral director, page	edical	(Check only 2 Medical E	Physician: To the besi exeminer: On the basis of and manner s	or examination a	ge, death ind/or inve	occurred at the time estigation, in my op	ie, date and plac pinion, death occ	ce, and due to the cau curred at the time, dat	ise(s) and m e and place	anner as st , and due to	ated. the cause(s)
	To the To the Comp	¥	29b. Signature and title of certifier	A	. ``		29c. License	number	296	d. Date sign	ed (Month, I	Day, Year)
	DAV.		1/ lu	- n	(1)		100	59975		3/20	106	
<	2011		30. Name and address of person v	who completed cause of ZG I	death (Item 23a)	(Type, P	BENUL	I, NeD	21811	1 t		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1		rer's Signature	A	-6	/	-			
	riegisti	CI	man o 1	7000	me of	do	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Day **Physician** Bert Beets D 28 2006 2350 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Nicomico SPUSBUM YONINSULA Year If Under 4 Hrs. 8. Date of Birth (Month, Day, Year) 2/9/1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**☎**M 2□F Months Days Hour Yrs. 79 Director 218-20-7335 New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 6979 Walston Switch Rd., Apt. 1 21804 USA Itеms 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 A Yes 2 NMarines Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🕱 Married 6 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify. white 3 ☐ Widowed 4 ☐ Divorced WW II "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be fited within Health and Mental Hygiene. Im 27 le marked other then " College (1-4or 5+) Elementary/Secondary (0-12) Broker Real Estate 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bert D. Beets Edith M. Chambers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 leany injury or other training one. Mary M. Beets/wife 6979 Walston Switch Rd., Apt.1, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4/1/06 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lige 22. Name and Address of Facility
Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Meremen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Inforotion Myocardia **Physician** /Medical Due to (or as a consequence of) Examiner rend insifficiency Chronic Acute on f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine nding physicien and use as the burial-transit The law requires that the death certificate be executed Rhabdo myolyris resulting in death) Last Due to (or as a consequence of): Box 68760, Cellulitis Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year Month 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be inector, page 2 s autopsy performed? Perficular 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referre examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 112 Inpatient 1 Tes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Z Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year, 3/29/ D0062130 2006 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) Salisbury 21804 4011 Healthw Andia James

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) MAR 3 1 2006 32. Registrar's Signature

			For State Registrar	State	of Mai	ryland		rtmen tificat				ental Hy	gien Reg. N	4 U U I	6	11952
	Physicia /Medic		Decedent's Name (First, Middle MARY	LOU		BROWN						2. Date of De Month APRIL		^a 2006 ^Y	ear	3. Time of Death 9:50 P M
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	Funeral Director		5. Social Security Number 219 34 7922	6. Sex 1 ☐ M 2 2 1 F		(In yrs. last	birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir Sept. I	th Year	37 !	Birthp	elace (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County			10c. City, T	own or Lo	cation							1	Od. Inside City Limits
	h the Maryland or 28a-f show	ctor	MD. MONT	GOMERY			DER	WOOD								1 ☐ Yes 2 No
	th with th	ai Director	10e. Street and Number 18005 MILL CREI	EK DRIVE				10f. Zip	0855				-	itizen of Wha		•
36	hours after deeth with the Maryland turet; or Itama 23a or 28a-f show al Exardinal must be inclifted at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	ned 1 ☐ Ye			"	Vas Deced Yes, spec	offy Cubar	spanic Or n, Mexical Specify:	n, Puerto	cify Yes or No Rican, etc.)	o-	14. Race - Black, Specify:	White,	etc.
2-0036	n 72 hour "natural edical Ex	ted b		it's Education	r Dates:	1	6a. Deced	lent's Usua	al Occupa	ition	st of worki	na	16b.	Kind ol Busir		
בבב	f within 72 jiene. r then "naf tre Medici	Completed	Elementary/Secondary (0-12)		e (1-4or 5+)	ACCOU	OO NOT u	se retired)	_	31 01 407741	<i>'</i> 9	CO	UNTY S	SCHO	OLS
Maryland	id be filed ental Hyg ked othe c event,	To Be C	17. Father's Name (First, Middle, ROY ELWOOD (GODFREY,	SR.	·					er's Name	(First, Middle		n Sumame) SMITH	1	
<u>Tary</u>	2 shoul and Miles mari	Ė	19a. Informant's Name/Relations	hip (Type, Print)		- 1		•	•	nd Numb	er or Rura	l Route Numb	er, City	or Town, Sta	ate, Zip	
	s 1 and 2 should Health and Mitem 27 is mar other traumati		JOHN ALLEN BROW			20b. Place	e of Dispos	sition (Nar	ne of			, DERW(MD. 2 Location - Cit		
Baltimore,	permit. Pages Department of Important: It its any Injury or o		1 Burial 2 Cremation 4 Donation 5 Other (S	(pecify)	om State	ST.	LUKE L				4/05			LAND,	MD.	
Ba	permit. Departi		21. Signature of Funeral Service	V. Ba	rehe	-						UNERAL TONSVIL			2088	32
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause o	n each line	l.	Do not ente						-			Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a	Lung to (or as a	Canc									+	
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7	w requires that been signed b should be deta	ρ	Part II. Other significant condition	ons contributing to	o death but	not resultir	ng in the un	iderlying c	ause give	n in Part I	l. 					ne cause of death?
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	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital	☐Inpatient	2	/Outpatien	3 DC	Othe			Check only one 5 ☐ Resi		6 Other	(Soecifi	, Hospice
on or	ling Afte	tlon: T	27. Manner of Death 1 Natural 5 Pendin 2 Accident investi	ng (M	te of Injury Ionth, Day	Year) 28	b. Time of Injury	M 2	8c. Injury Work		2	28d. Describe				· · · · · · · · · · · · · · · · · · ·
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	To the I within 2. To the I complet	Me	29b. Signature and tille of certifit		15 .	^ _		_	. License					ate signed (/		
	10		30. Name and address of perion	who completed c	ause of dea	ath (Item 23	Ba) (Type, I	Print)	356	30	-		APK.	IL 3,	ZUU	O
			Joseph Kaplan, 31 Date liled (Month, Day, Year)	M.D.,600		ncaste	er Mi	11 Rc		Rock	ville	, Md.	208	855		
	Sta Registr		E D D TH	4 2006	rwyistrar	s Signature	A	and I	9							

			For State Registrar	State	of Marylar		artmen rtificat				,	giene	06	119	53
			1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea	ath	V	3. Time of	Death
	Physici /Medio		EVELYN M.	BROWN							March	30,	2006	4:40	P ^M
	Examir		4a. Facility Name (If not institution	n, give street and n	iumber)		4b. City,	Town, or	Location of	of Death		4c. Cou	inty of Deat	th	
			Shady Grove Ad	lventist	Hospita]	L		ckvi				Mon	tgome	ry	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔯 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)	Co	hplace (State o	-
	Director		002-14-1395 Usual Residence of Decedent		82	Yrs.					Dec. 12	2, 192	3 New	Hampsh	ire
	and w		10a. State 10b. County	/	10c. C	ity, Town or Lo	cation							10d. Inside Ci	ity Limits
	Many	ō	Md. Monts	gomery	Ga	ithers	huro							1 X Yes	2 🗌 No
	1 the	ē	10e. Street and Number	Somery		· · · · · · · · · · · · · · · · · · ·	10f. Zip	Code				10g. Citizen	of What Co	ountry?	
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	death	Funeral Director	11. Marital Status	12. Was De	cedent Ever in L Forces?	J.S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)		Race - Ame	nican Indian,	
ဖွ	after or its	F	1 Never Married 2 Mar		2 X No	•	1 ⊟ Yes		Specify:		HICAN, OC.)		Black, White ec <i>ify:</i> Wh	•	
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Ω.	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f ehow fre Medical Exercifer must be notified at	Completed	15. Deceder (Specify only highe	nt's Education est grade completed	1)	16a. Dece	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ation <i>Juring m</i> os	t of work	ring	16b. Kind o	f Business/	Industry	
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Maryland 21215-0036	should he ma		19a. Informant's Name/Relations					,			al Route Numbe				
Σ.	and 2 palth n 27	0.33	Dr. Cynthia St	evens (Da		_			Mano	or D	rive Mc	Lean,	Va.	22101	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23a or 28e-f show enty intry or other traumatic event, the Medical Examination must be notified at once.	i "	20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from	n State	Place of Dispo cemetery, crer	natory or o	ther place		Marc	h 31,	20c. Locatio	•		
Ë	ritmen ritmen ritmen ritmen		4 Donation 5 Other (S		Me	tropoli			• !	20	06	Alexar		Va.	
Bal	Depermine Important Important In Sunce.		21. Signature of Funeral Service	? Stee	1	1		t De	er Pa	ark]	Vol Fune Dr. Gait	hersb		Md. 208	77
U			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause of	caused the dea each line.	th. Do not ent	er the mod	le of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	a Suc	lden &	profour	19	bra	d407	adu	à,			Onset and I	Death
	/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of):		_	J						
		-	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consec	quence of):								/	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	{											
ó	exection and rial-tra	Exa	resulting in death) Last	C. Due to	o (or as a consec	quence of):									
8760,	cate be executed physicien and the burial-transit	dlcal		d											
9	artifica ing ph e as t	Med	IF FEMALE:												
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregn birth 2 Peta	al death 3 □	Ectopic pr						Date of deli Month		/ear
o.	Attending Physicien: The law requires thet the death certific roteath. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as by the funeral director.	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pre	gnant at time of o cnown	death 5	Other (sp	ecify)						,	
م َ	thet to		Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	bacco use c	ontribute to	the cause of d	eath?
g	puires n sign lid be	d by	cerebellar	homan	geo blas	toma					1 🗆 Y	′es 2□No	3 ☐ Pro	obably 4 🗹	/ Jnknown
<u>o</u>	s been si should	lete	bronchiect	7.9LS							24a. Was a	an 24	lb. Were au	topsy findings a	available
æ	hysicien: The lav his certificete has I director, page 2	Completed	parux45m.		1 fibr.	llation	,		,		autop	rmed/	prior to death?	completion of ca	ause of
ta	en: rtifice tor. p	0	25. Was case referred to medica				<u> </u>		26. Place	of Deat	1 ☐ Yes h (Check only o		1 1 1 105	2010	
>	nysic ais ce direc	To B	examiner? 1 Yes 2 No	Hospital: 1€	Inpatient 2	ER/Outpatien	t 3 DC	Othe)r		me 5 Resid		Other (Spec	cify)	
0	ng Pt fter tt ineral		27. Mangrer of Death 1 ☑Natural 5 ☐ Pendi	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury	2	8c. Injury Work	at		28d. Describe h	ow injury oc	curred		
Sio	eath. or: A the fu	catle		igation			М		/es 2 □	No					
Division of Vital Records,	or Att	Certification;	4 Homicide determ	nined 286. Place	ce of Injury - At h ding, etc. (Speci	iome, farm, str fy)	eet, factory	, office			28f. Location (S City or Tow	itreet and Nu m, State)	imber or Ru	ıral Route Num	ber,
L	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 Certifyi	ng Physician: To ti	he best of my kn	owledge, death	occurred	at the tim	e, date an	d place,	and due to the o	ause(s) and	manner as	stated.	
	To the Ho within 24 To the Fu completel	Aedical	one)	Examiner: On the and ma	basis of examina inner stated.	ation and/or in	vestigation,	, in my op	oinion, dea	th occur	red at the time, o	date and plac	ce, and due	to the cause(s)
	To To	Σ	29b. Signature and title of certifie) P			290	: License	number	10	1			n, Day, Year)	36
•	_		1 / 1 / 1	-1754	~		1	1. 7	-01	7.7		121.01	1001	1200	10
	8		30. Name and address of person Dr. Steven Do1		·	m 23a) (Type, Russe1:	,	. G	aithe	ershi	ırg, Md.	2087	7		
	Sta	te	31. Date filed (Manth Pay, Year) 32,	Registrar's Sign	atura 4					- 0,				
	Registr	ar	APR 0	4 2006	aliser 1	J. Age	and I								

			1 - For State of Maryland / De State of Maryland / De		ment of He			giene)	11954
	Physici	an	Decedent's Name (First, Middle, Last)				2. Date of De		Year	3. Time of Death
	/Medic	al	ELIZABETH W. BELT 4a. Facility Name (If not institution, give street and number)		b. City, Town, or I	Landing of Dog	MARCH	31 200		8:10 P M
	Examir	er	WILSON HEALTH CARE CENTER	40	GAITHER		au i	MONTGO		
	Funeral Director		5. Social Security Number 215 01 4188 6. Sex 1 M 2 F 106 Yrs	Mo	f Under 1 Year Ionths Days	If Under 24 Hr Hours Mir		y, Year) 1899		lace (State or Foreign try) LAND
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the county						11	Od. Inside City Limits
	e Man la-f sh	ctor	MD. MONTGOMERY GAITH	ERSE	BURG 					1,⊠Yes 2□No
	with th	Dire	10e. Street and Number 301 RUSSELL AVENUE	1	10f. Zip Code 20877	,	1	10g. Citizen of WIUNITED S		•
	death ms 23	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was	s Decedent of His	spanic Origin? (Specify Yes or No	14. Race	- Americ	an Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show among yilury or other traumatic event. The Medical Examinar must be notified at ODGE.	by Funeral Director	Amned Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	_	es, specify Cuban Yes 2 No	Specify:	erto Rican, etc.)	Specify:	White, WHI	
5-0	"natu	letec	(Specify only highest grade completed) (C	Give kina	t's Usual Occupat d of work done du NOT use retired)	uring most of w	orking	16b. Kind of Bus	iness/Inc	lustry
212	d withir piene. rr than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	CRET				STATE O	F MA	RYLAND
pu	be file tal Hyg d othe	Be	17. Father's Name (First, Middle, Last)				ame (First, Middle,			
r <u>ya</u>	hould d Men marke matic	ဥ	GEORGE LEACH FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. N	Aailing A	Address (Street at	MARTHA	A DARBY			Code)
	alth an 27 is ar trau						1509, Lan			
Baltimore,	of Heritam		11 Huriai 2 Micremation 31 Hemovalitom State 1	cremato	ory or other place		Date	20c. Location - C	-	
Ħ.	it. Pag intment intant: I njury o		4 Donation 5 Other (Specify) Metropol 21. Signature of Funeral Service Licensee					Alexandr	ia,	Va.
Ba	Depar Impor any in		Murul H. Barker				FUNERAL AYTONSVIL		2000	2
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.						<u> 2 U</u> OD	Approximate Interval Between
	Physician .		Immediate Cause (Final disease or condition resulting in death)	2						Onset and Death
Е	/Medical Examiner		Due to (or as a consequence of)	:					'	S)
	± σ	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Lissass or injury	:						
_	icate be executed physicien and s the burial-transit	Examine	Causs (Lissass of injury that initiated events c	:					-	
8760,	e be e /sicien e buria	dical E	d							
Ó	ing phy a as th	Medi	IF FEMALE:							
.O. Box	e death certifice the attending pland the for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 poinths? 1 Yes 2 No 9 Unknown		topic pregnancy ther (specify)			23d. Date Mont		ry Day Year
<u>a</u> .	res that the de igned by the a be detached t	/ Phy	Part II. Other significant conditions contributing to death but not resulting in the	ne under	rlying cause giver	n in Part I.	23e. Did to	obacco use contrib	oute to th	e cause of death?
rds	w requires been sign should be	ed by					101	res 2□No 3	☐ Prob	ably 4 dunknown
Reco	S S	Completed						rmed? pri	or to con ath?	osy findings available inpletion of cause of
ita	ien: T	Be Co	25. Was case referred to medical			26. Place of De	1 ☐ Yes eath (Check only o		Yes	2 NO
))	Physicien: r this certific ral director,	P.	examiner? Hospital: 1 Inpatient 2 ER/Outpa		3 □ DOA Other	4 Paursing	Home 5 Resid		-)
ono	ding F h. After funera	tlon:	27. Manngs of Death 1 Matural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Inju	ıry	28c. Injury Work? M 1 7	at ? es 2 ∐ No	28d. Describe I	now injury occurred	d	
Division of Vital Records,	i or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street,	factory, office		28f. Location (S City or Tov	Street and Number vn, State)	or Aura	l Route Number,
	Hospite 4 hours Funerei tely fillec	edical C	29a. Certifier (Check only one) 1	leath occ or investi	curred at the time	e, date and place inion, death occ	ce, and due to the curred at the time,	cause(s) and mani date and place, an	ner as st id due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	number	1	29d. Date signed	(Month, I	Day, Year)
	No.		30, Name and address experson who completed cause of death (Item 22e) (Ty	/pe, Prin	it)	2017	0	17641	1	2006
	3		Steven Volinsky 911 Kus		1) Ave	62	ithers bur	5 m	7.	
	Sta Registr		31. Date filed (Moeth, Day, Year) 32. Registrar's Signature	Good	de					

hysic /Medi		1- State RegistraAmend Item 1. Decedent's Name (First, Middle, I	last) Genevieve		liflowe				2. Date of April 1		^{ay} 2006 ^{Year}	3. Time of Death 0815
Exami		4a. Facility Name (If not institution, g Northampton Mar	ive street and numb nor Health	°r) Care	Center			Location of D	eath	40	County of Death Frederic	
ineral rector	V=10	5. Social Security Number 212-38-9156	Sex 7. 1 □ M 2 □ ▼F	Age (In yrs 91	, last birthday) Yrs.	If Under Months	Days	If Under 24 Hours	Hrs. 8. Date of (Month, Octobe	Birth Day, Year er 2,	1914 ^{9. Birth}	place (State or Forei ntry) Maryland
lad at	tor	10a. State 10b. County	lerick	10c. C	ity, Town or Lo		rede	rick				10d. Inside City Limit
volcal Examiner must be notified at	al Director	10e. Street and Number 200 East Sixteer	nth Street			10f. Zip	Code Fi	rederic	k	10g. C	itizen of What Cou	Ü.S.A.
Examinarmu	by Funeral	11. Maritaf Status 1 Never Married 2 Married 3 XX idowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? XNo	ł	Vas Deced f Yes, sped		ispanic Origin' n, Mexican, P Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Amen Black, White Specify: Wh:	
event, the Mudical	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		or 5+)	16a. Deced (Give life. L Homema	kind of wo DO NOT u	al Occupa ork done o se retired	ation during most of)	working		Gind of Business/fr	ndustry
	To Be C	17. Father's Name (First, Middle, La. Hanson Baker	st)						Name (First, Midd ha M. Ba		n Sumame)	
other traumatic ev		19a. Informant's Name/Relationship Harry Philip Kr	antz, Son		4486	Willa	ow Ti	cee Dri	ve, Midd	lleto	or Town, State, Zij wn, MD 2	L769
č		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	,,	teRest	Place of Dispo cometery, cren naven M	sition (Nar patory or o IEMOT	ne of xher-plac LAI (ardens	s April 1	20c. L	ocation - City or T 206 Fred	own, State derick, M
any injury or ottos.		21. Signature of Funeral Service Lic	C. Hasf	ark		106	6 Eas	st Chur	sford Fu	t. F	l Home rederick	MD 2 17 01
ician dical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each	lult f	ailure	er the mod	le of dying	g, such as can	diac or respiratory	arrest,		Approximate Interval Between Onset and Death MONTAS
iner	er.	1	ь Ме	as a consec ningi as a consec	oma							years
the burial-transit	ai Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or									
tached for use as the	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 Feta	al déath 3 🗆	Ectopic pr Other (sp					23d. Date of deliv Month	ery Day Year
pe de	ρ	Part II. Other significant conditions	contributing to death Atrial f	ibut not res	sulting in the un	derlying c	ause give	in in Part I.		•		he cause of death?
page 2 shou∤d	Completed					-				topsy formed?	prior to co death?	opsy findings availab impletion of cause of
director, p	Be	25. Was case referred to medical examiner?	Hospital:				055		Death Check only			
funeral di	ion: To	1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending	28a. Date of li		28b. Time of Injury		8c. Injury Work	Nursin	g Home 5 Re 28d. Describ		6 ☐ Other (Specin ry occurred	(y)
d in by the	ertification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At h etc. <i>(Speci</i>	ome, farm, stre			2 110		(Street ar	nd Number or Rura e)	al Route Number,
y fille	edical C	29a. Certifier (Check only one) 2 Medical Example (Check only one)	Physician: To the be aminer: On the basis and manner	of examina	owled je. death ation and/or inv	occurred estigation,	at the tim , in my op	e, date and li inion, death o	and and due to the courred at the time	e nausa(s a, date and	and marinar as s diplace, and due to	the cause(s)
letel		con or a set the et emplies				29c	. License	number		29d. Da	te signed (Month,	Day Year)
completely filled in by	Σ	29b. Signature and title of certifier	_			1					-10-2 -, mp =	

			. For	State of Marylan					•	•	ible.	
			1 - State Registrar		Cei	rtifica	te of Death			Reg. No.	6	1956
y:	Physici	ian	Decedent's Name (First, Middle, Last)					2	2. Date of Dea	Day	Year	3. Time of Death
1	/Medi Examir		Rose Ann Cheeks 4a. Facility Name (If not institution, give s			4b. City	, Town, or Location of	of Death	3 2	28 0 4c. Count		6:50p ^M
	Examil	iei	Southern Maryl		a 1		nton					eorges
	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		r 1 Year If Under	24 Hrs. 8 Min.	Date of Birt	h		place (State or Foreign
*	Director		249-40-1115 Usual Residence of Decedent	M 2KJF 82	Yrs.				/6/23	3		<u>Carolina</u>
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Ba-f el	Director	MD Prince G	eorges For	cestv:	i11e						1X Yes 2 □ No
	ours after death with the Marylan ral', or items 23a or 28a-1 ehow Examirer must be notified at	Dire	10e. Street and Number				p Code			10g. Citizen of	What Cou	ntry?
	leath i	Funeral	3335 Walters I	ane #3 12. Was Decedent Ever in U	S 13 V		20747	gin? (Snec	fy Yes or No-	USA 14 Ba	ce - Ameri	can Indian,
9	after d		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give	'		dent of Hispanic Ori ocify Cuban, Mexican	, Puerto Ri	can, etc.)		ck, White,	etc.
21215-0036	72 hours after death with the Maryland Instural', or items 23a or 28e-f show dical Examiner must be putilled at	d by	3 XWidowed 4 □ Divorced	Year or Dates:		1 🗆 Yes	21X No Specify:			Specii	fy: Bla	ack
15-	n 72 ho "natur edical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	dent's Usu kind of wo	ial Occupation ork done during mosi use retired)	t of working		16b. Kind of B	Business/In	dustry
212	l within 7 liene. r then "n Ine Med	omp	Elementary/Secondary (0-12) 6th	College (1-4or 5+)	Hous					domes	stic	
פָּ	Hyg The	Be C	17. Father's Name (First, Middle, Last)		1		18. Mothe	er's Name (First, Middle,	Maiden Sumai	me)	
ylar	D € 0 0	ToE	Willie Colema	n			Laur	a Br	iggs			
Maryland	and and ie m		19a. Informant's Name/Relationship (Type Patricia A. Eve	[®] Daughter	19b. Mailin	g Addres	s (Street and Number	er or Rural F	Route Numbe	r, City or Town	, State, Zi _l	2 2 3 3
	1 an Heal em 2 ther		20a. Method of Disposition	ans/	lace of Dispo	Hand sition (Na	COCK Str	eet	Brook	lyn, N 20c. Location	lew :	ork
Baltimore,			1 XBurial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	-		1/1/0				
alti	글 문원금 .		21. Signature of Theral Service License		22	Name	nd Address of Engilit					Maryland
8	Depa Impo eny i		Kisa a. I	Yeury	42	20 H	enry Fur Street	NE W	lashin	er inc gton :	DC 2	0002
			23a. Part1. Sater the disease, or complice shock, or heart failure. List only on	cations that caysed the deat e cause on each line.	n. Do not ent	er the mod	de of dying, such as	cardiac or r	espiratory ar	rest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Carchem	upathy		, Marie					Onset and Death
4	Examiner		1	Due to (or as a conseq		. N:	Seuse					
	D. W.	Jer	Sequentially list conditions, b	Due to (or as a conseq	nce of):	3	Him	-				
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
,092	ite be executed sysicien and ne burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):							
687	5 × 6	dical	d								-	
Box 6	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna	ncy			\$2 A		23d Da	ite of deliv	arv.
œ.	0 60	icia	in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\sum \text{No} \)	1 Live birth 2 Fetal		Ectopic p Other (s)					onth	Day Year
P.O.	that the de ned by the a detached f	Phys	9 Unknown	9 Unknown								
	9 'Q' 9	þ	Part II. Other significant conditions con acute Ren AL Failure	-	alting in the ur	nderlying (cause given in Part I.		23e. Did to			ne cause of death?
ŏ	w requir been s should	Completed	00001 C14-1712 1 cot 00- C							- 38		
Rec	The lav	mp							24a. Was a autop: perfor	SV	Were auto prior to co death?	psy findings available mpletion of cause of
ta		Be Co	25. Was case referred to medical	Y		17	26 Place	of Death //	1 ☐ Yes Check only or	2 No	1 🗌 Yes	2 No
<u>></u>	ding Physician: h. After this certific funeral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Impatient 2 I	ER/Outpatien	t 3 🗆 D0	Other			ence 6 Oth	ner (Specif	y)
0	ding Pt n. After tt funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?	280	d. Describe h	ow injury occur	red	
sio	Attending r death. ector: After y the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	On Place of lawy At he		M	1 Yes 2 1					
Division of Vital Records,	in Sir de	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factor	y, office	28	City or Tow	treet and Numb n, State)	ber or Rura	il Route Number,
_	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	wledge, death	occurred	at the time, date and	d place, and	d due to the c	ause(s) and ma	anner as s	tated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Wedical Examina one)	er. On the basis of examinat and manner stated.	ion and/or inv	estigation	, in my opinion, deat	th occurred	at the time, o	late and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of/certifler			29	c. License number		2	9d. Date signe	d (Month,	Day, Year)
0	TII		1 IVW			D	0055120			Merch	429	2006
K	4		30. Name and address of person who cor Rithard Palmer MD	npleted cause of death (Item	23а) (Туре,	Print)	00 55120 E Smh 310	2 W	in hi	b. Dr	701	732_
W. Co	Sta	te	31. Date filed (Month, Day, Year)	22. Registrar's Signa	ture	- J	C 420110 210		7 700 112	NOW DE		
	Registr		APR 0 3 2006	Box 16	4	20						

			For State Registrar	State of M	iarylan		artment of rtificate c		d Mental Hy	- 0	1000	116	150
	#		Decedent's Name (First, Middle, Las	t)				Douin	2. Date of D				of Death
	Physici /Medio		MILDRED		CRA	WFORD			MARCH	27	2006		33 A M
	Examin		4a. Facility Name (If not institution, give	street and number			4b. City, Town	n, or Location of C	eath	4c	. County of D	eath	
			PRINCE GEORGE'S					EVERLY		P	RINCE	GEORGE'	S
	Funeral		5. Social Security Number 6. Se	9x 7.A □M2 <u>1</u> 27F	ge (In yrs. 75	last birthday) Yrs.	If Under 1 Ye Months Day		Min. (Month, D	ay, Year)		Birthplace (State Country)	
	Director		578-42-4967 Usual Residence of Decedent		13	113.			MARCH	21 1	.931 V	VASHINGT	ON, DC
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside	City Limits
	B-1-9	ctor	MD PRINCE G	EORGE'S		MT RA	INER					1) () Ye	s 2 No
	or 28	Director	10e. Street and Number				10f. Zip Cod			10g. Cit	tizen of What		
	a 23a		4110 31st STREET				2071				U.S.A		
	ter de Item	Funerai	11. Marital Status 1 □ Never Married 2X Married	12. Was Decedent	?		Was Decedent of f Yes, specify C	of Hispanic Origin uban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - A Black, W	merican Indian, 'hite, etc.	
936	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠ If Yes, Give Year or Dates:			1□Yes 2X□N	lo Specify:			Specify:	BLACK	
Ģ	be filed within 72 hours after deeth with the Maryland Hygiene. d other than "natural", or itema 23a or 28a-f show event, the Madical Examiner must be mulified at	Completed	15. Decedent's Ed				dent's Usual Oc			16b. K	ind of Busine	ss/Industry	
2	thin 7	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT use ret	ne during most of ired)	working				
2	filed w Hygier other th	Cor		2yrs		HOM	E MAKER				PRIV	ATE	
_	ould be fi Mental H arked oti atic ever	Be	17. Father's Name (First, Middle, Last)						Name <i>(First, Middle</i> COLLISTER		,		
Ž	should be nd Menta marked umatic ev	ဥ	HERMAN JOHNSON 19a. Informant's Name/Relationship (7)	ivna Print)		10h Mailie	Addross (Ctro		r Rural Route Numb			7:- 0- 1-1	
	2 2 2		CLAUDETTE CRAWF	VQ	Tr.D	0.55						eranorma-	
ē,	f Health if Health item 27 other tr		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other p		. Washing			or Town, State	
Baltimore,	permit. Peges 1 Department of H Important: If ite eny injury or ot ance.		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		9	•	E CREMAT		3/2006	RIV	ERDALE	, MARYLAI	ND
att	rmit. spartn sports y inju		21. Signature of Funeral Service Licen:	see 1 /		22	. Name and Add	dress of Facility	J. B. JI				
<u> </u>	897		K.D. No	half					DAD LANDO		1ARYLAI	ND 2078	35
			23a. Part1. Enter the disease, or comp shock, or heart failule. List only of	lications that cause one cause on each	d the death	h. Do not ente	er the mode of o	tying, such as car	diac or respiratory a	rrest,		Approxima Interval Be	etween
	hysician		Immediate Cause (Final disease or condition resulting in death)	a LUN	IG CAN	ICER						Onset and	Death
	/Medical Examiner		1	Due to (or as	s a conseq	uence of):							
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequ	uence of):				_			
	cuted	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C.									
Õ	e exe ien ar urial-t	Ex	resulting in death) Last	Due to (or as	s a consequ	uence of):							
09/8	the death certificate be executed y the ettending physicien and iched for use as the buriat-transit	dicai	•	d								-	
×	eath certific ettending p	/Me	IF FEMALE:	23c. If yes, outcome	e of pregna	ncv							
POX	etter of for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	Ideath 3□	Ectopic pregnal Other (specify)				23d. Date of Month	Day	Year
		hysi	9 Unknown	9□ Unknown									
S,	law requires thet as been signed b 2 should be deta	by P	Part II. Other significant conditions co	ntributing to death t	but not resu	ulting in the ur	nderlying cause	given in Part I.	23e. Did	tobacco u	use contribute	to the cause of	death?
Hecords,	equir sen si ould I	ted							_ 5	Yes 2	□No 3□	Probably 4]Unknown
Ö.	e law r has be je 2 sh	Completed							24a. Was		prior	autopsy findings o completion of	s available cause of
_ ;	icete ha	Sol							perfe 1 ☐ Yes	ormed? 24☐Alo	death	? 37	
VIII VIII	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital: A.				No	Death (Check only				
		2	1 Yes 2 No	28a. Date of Inju	UIV	ER/Outpatien 28b. Time of	, oll box		g Home 5 ☐ Res 28d. Describe			Decify)	
<u>.</u>	Attending Property of the funeral by the funeral control of the fune	tior	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	28c. In W	lork? □Yes 2□No	203. 20301120	now and	y 00001100		
DIVISION	r Attendii er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of in	jury - At ho tc. (Specify	me, farm, stre	eet, factory, offic	20	28f. Location (Street an	d Number or	Rural Route Nu	mber,
ַ בֿ	rs after or rail Direction								City or To				
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	Check only Z Medical Exam	rsician: To the best iner: On the basis of	or examiniai	wledge, death tion and/or inv	occurred at the	time, date and pl	ace, and due to the	cause(s)	and manner	as stated. lue to the cause	(s)
	ithin 2 of the	Med	29b. Signature and title of pertifier	and manner st	tated.			nse number				onth, Day, Year)	
,	6 4 5 -		Jornaul X 2	Vista m			1	7.1	438	MA	2/H 2	n 200	7
0	(10)		30. Name and address of person who c	ompleted cause of	death (Item	1 23a) (Type. I	Print)		1-0	1114	ه زان	- 2000	٥,
1			MICHAEL J. LAPEN		,			AY ANNAPO	OLIS MARY	LAND	21401		
1 (2)	Sta Registra		31. Date filed (Month, Day, Year) APR 0.3 2006	32. Regist	rar's Signa	ture	٠.						

			For State Registrar	State of Marylar	nd / Departm <i>Certific</i>				giene Reg. No. 0 0 6	11959
*	Physic		1. Decedent's Name (First, Middle, Last) LARRY MICHAEL C					2. Date of Dea	Day Year	3. Time of Death
	/Medi Examir Funeral		4a. Facility Name (If not institution, give s 9403 6 Len Tr 5. Social Security Number 6. Sex	ce Park S	Treet C	ity, Town, or	Location of Dea	ath S. B. Date of Birt	4c. County of Death	
	Director		578 - 58 - 5481	IM 2□F 59	Yrs. Mont	hs Days	Hours Mi	n. (Month, Da)	7, 1947GEO	intry)
	Maryland	tor	10a. State 10b. County MD PRINCE	GEORGES CAP	ty, Town or Location 21701 HEI	GH7S				10d. Inside City Limits 1√Ω Yes 2 □ No
	th with the 23a or 28.	al Director	10e. Street and Number 9403 GUMTREE PA.	RK STREET		Zip Code 20743			10g. Citizen of What Co.	untry?
9036	72 hours after death with the Maryland natural', or items 23a or 28a-f show sistal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1	i	ecedent of H specify Cuba s 2/2/No	ispanic Origin? (In, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: BLA	, etc.
21215-0036	within liene.	Completed	15. Decedent's Edui (Specify only highest grade Efementary/Secondary (0-12) 127 H	cation e completed) Colfege (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO INDEPEN	work done o T use retired	during most of w ()		16b. Kind of Business/I SELF EMPL	,
Maryland	s 1 and 2 should be filed if Health and Mental Hyg Item 27 Is marked othe other traumatic event,	To Be (17. Father's Name (First, Middle, Last) BEN CALLAWAY				Mary	ame (First, Middle, Callaway		
_	and 2 sho salth and n 27 is m		19a. Informant's Name/Refationship (Ty) WANDA NELSON/ D						r, City or Town, State, Z MD 20735	ip Code)
Baltimore,	Page ent o nt: If		20a. Method of Disposition 1 Ä Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Disposition (cometery, crematory) SURRECTI	or other plac		Date R. 27, 200	20c. Location - City or 1	
Balt	permit. Pac Departmen Important: any injury once.		21. Signature of Funeral Service License	nderson	22. Name DUN	and Addres	ss of Facility $S = 5635$	EADS ST	T.NE WASHI	INGTON DC
· · · · · · · · · · · · · · · · · · ·	Physician /Medical Examiner		23a. Perty. Enter the disease, or compli- shock, or heart failure. List only on fmmediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	devotic					Approximate Intervat Between Onset and Death
8760,	sate be executed oblysicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec						
O. Box 6	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 □Ectopi	c pregnancy (specify)			23d. Date of deliving Month	very Day Year
rds, P	9 <u>10</u> 9	by	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause give	en in Part f.	_	obacco use contribute to res 2 □ No 3 □ Pro	the cause of death?
of Vital Records,	The law ate has b page 2 sl	Completed								opsy findings available ompletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examined? 1. Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA Othe		eath (Check only of	ne) lence 6 □Other (Spec	ifu)
ion of	Attending Phirdeath. sctor: After thi by the funeral of		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			ow infury occurred	.,,,
Division	Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At h building, etc. (Speci		tory, office		28f. Location (S City or Tow	itreet and Number or Rui n, State)	ral Route Number,
	Hospital 24 hours a Funeral I	edical (29a. Certifier 1 Certifying Phys	sician: To the best of my known or the basis of examinating and manner stated.	owledge, death occur ation and/or investigat	ed at the timion, in my of	e, date and place pinion, death occ	ce, and due to the courred at the time, of	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 1 1		29c. License		à	29d. Date signed (Month	, Day, Year)
0	8		A Trada /	moleted cause of death "	D 22a) (Timo Brier)	Ho	359	27	March 23	3 2006
	(2)		30. Name and address of person who co	vsty 300,	1 Hospita	EL D	rive	Chor	4 MAR	lowd
	Sta Registi		31. Date filed (Month, Day, Year) MAD 3 1 2006	32. Registrar's Signa	books		,			

State

I FILL III DIACK IIIQUIDIE IIIK. Elisure A	
of Maryland / Department of Health and	Mental Hygiene 006 1960
Certificate of Death	Reg. No.

			For State Registrar			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Certific	cate o	f Death	7	o	Reg. No.	UUU	1 1 .
	Physici /Medic		1. Decedent's Name	e (First, Middle, La he l	STOOK							2. Date of De Month	Day	Year	3. Time
	Examin			Vursing	and Rei	habilite		Center	~	or Location	of Death		4c.	County of Deal	
	Funeral Director		5. Social Security N 217 03 18	319	Sex I□M 2√2 F	7. Age (<i>In yr</i> s. 94			Inder 1 Yea oths Day		Min.	8. Date of Bir (Month, Da Jan• I	Ž, 191	9. Bird Co Mar	thplace (State Dunity) yland
	Maryland -f show	tor	Usual Residence of 10a. State Maryland	10b. County Worcest	er	10c. Ci Ocea		or Location	1						10d. Inside
	with the	I Directo	10e. Street and Nur					10	f. Zip Code				10g. Citiz	zen of What Co	ountry?
920	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show mixportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ship injury or other traumatic event, the Madical Examinar must be notified at ances.	by Funeral	11. Marital Status	ried 2□ Married		2 X No ∕e	J.S.			f Hispanic O uban, Mexica		cify Yes or No Rican, etc.)	0- 1	4. Race - Ame Black, Whit	
21215-0036	d within 72 ho giene. ir then "natur ithe Madical	Completed	(Special Special 15. Decedent's E- cify only highest gra andary (0-12)	ducation ade completed) College (1	-4or 5+)	16a. Sa.	life. DO N	of work dor	ne durina mo	st of workin	g		nd of Business		
Maryland	ould be filed Mental Hyg larked othe latic svsnt,	To Be C	17. Father's Name Richard S	Seaburs						Rose	Lane		, Maiden	Sumame)	
	ges 1 and 2 sh it of Health and if Item 27 is m or other traum		D. CLiffo			205	900)3 Eas	st Bis		Dr.	0cean	City		21842
OLO Baltimore,	Pages 1 ment of H ant: If Ite lury or otl		4 Donation	Cremation 3 5 Other (Specil	(y)	State	cemeter		orother p en Cre	emator	y 4/2		Fran	cation - City or ikford,	DE
Balt	permit. Page Depertment of Important: If any injury or		1/1	ine il Service Lice	whas.			The	Burba		neral	Home	Berli	Villiam Ln, MD	St. 21811
	Physician /Medical Examiner		23a. Part 1. Enter to shock, or hea Immediate Cause disease or condition resulting in death)	on	a Do	aused the dea lach line. eumo (or as a consec	ni	a	mode of d	lying, such a	s cardiac or	respiratory a	irrest,		Approximation interval Be Onset and
		Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	rinjury s	c	(or as a consec									
68760,	rtificate be executed ng physicien and as the burial-transit	Medical Ex	resulting in death) i	Last	Due to	or as a consec	quence o	of):							!
P.O. Box 6	Attanding Physician: The law requires that the death certific rideath. sctor: Atter this certificate has been signed by the ettending by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 € 9 ☐ Unknown	months?		oirth 2 ☐ Feta ant at time of a	al death		pic pregnar er (specify)				2	3d. Date of de Month	livery Day
rds, P.	v requires that been signed by should be deta	þ	Part II. Other signif	ficant conditions	contributing to de	eath but not re	sulting in	the underly	ing cause	given in Part	I.		tobacco u Yes 2	se contribute to	o the cause of
Division of Vital Records,	The law reate has bee page 2 sho	Completed										24a. Was auto perfe 1 Yes		24b. Were as prior to death?	utopsy finding completion of
of Vita	for Attanding Physician: The I after death. Director: After this certificate ha I in by the funeral director, page	To Be C	25. Was case referexaminer? 1 Yes 2	+16] ER/Ou	tpatient 3[_ DOA	Other: 4 4		(Check only	one)	i □Other (Spe	icify)
sion o	ending Pi aath. or: After ti he funeral	ertification:	27. Manner of Deat 1 Shatural 2 Accident	5 ☐ Pending investigatio	n	of Injury th, Day Year)		ime of njury M	28c. In W	lury at Vork? ☐ Yes 2 ☐		8d. Describe	how injury	occurred /	
Divis	l or Atts after de Dirscto	ertific	3 Suicide 4 Homicide	6 Could not be determined	286. Place	of Injury - At I ng, etc. (Speci	iome, fa	rm, street, fa	actory, offic	ce	2	8f. Location (City or To	Street and wn, State)	d Number or R	ural Route Nu

To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea
---	--

of pregnancy 2 ☐ Fetal death ime of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)

23d. Date of	deliver
Month	

Part II. Other	significan	t conditions	contributing to	o death but not	t resulting in the	ne underlying	cause given	in Part I.

23e. Did tobacco use	e cont	ribute to t	ne caus	e of death?	?
1 ☐ Yes 2 ☑	100	3 ☐ Prob	ably	4 Unkno)\
24a. Was an autopsy performed?	24b.	Were auto	psy find mpletion	dings availa	C
1□ Yes 2 No		1 🗆 Yes	2 1 N	5	

3. Time of Death

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits 1 √Yes 2 No

5:10 P

Approximate Interval Between Onset and Death Weeks

Year

					_					
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ ₩0		26. Place of Death (Check only one)								
	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other: 4 Nursing H	fome 5 ☐ Residence	6 ☐Other (Specify)				
27. Manner of Death	28a. Date of Injury	28b. Time of	28c. l	Injury at	28d. Describe how in	ury occurred				

27. Manner of Death 1 ☑Natural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 Yes	2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	me, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	120	ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
(Check only	2 🗆 N	ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
one)		and manner stated.

Unej	and manner stated.		
29b. Signature and title of	certifier	29c. License number	29d. [
Val. T.	1 All 141. 110	6	11

Date signed (Month, Day, Year) -2-2006 01-0006191

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1209 COASTA-HIGHLAY, FELLICK ISLAND, DE 19944 KRISTINE GRIFFIN 31. Date filed (Month, Day, Year)

State Registrar

APR 0 4 2006



			1 - For State Registrar	State of Maryland		nt of Health a te of Death		ene	1961
, 7	Physici /Medio		1. Decedent's Name (First, Middle, Last)	A	Char	dwick.	2. Date of Death	30 Zool	3. Time of Death
1 1 ×	Examin Funeral Director		4a, Facility Name (If not institution, give s 5. Social Security Number 6. Sex 217-30-8340	Hospital Ca		er 1 Year If Under 2	JWA	4c. County of Deat 9. Birl CC 31, 1934	th hplace (State or Foreign huntry) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	r, Town or Location				10d. Inside City Limits
	e Marylan ta-f ehow	ctor	MD KENT		CHESTERTO	OWN			1 ☐ Yes 2X No
	ath with th	ral Director	10e. Street and Number 8669 GEORGETOWN	ROAD	2	21620		og. Citizen of What Co	ountry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "nature!, or iteme 23a or 28a-f ehow other traumatic event, the Medical Examinational De notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	12. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		edent of Hispanic Orig ecify Cuban, Mexican, 2 No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
21215-0036	within 72 ho iene. • then "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT HOMEMAKE	vork done during most use retired)	of working	OWN HOME	Industry
Maryland 2	ould be filed Mental Hygis arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) ERNEST P. YOUNGER				r's Name (First, Middle, MINIE M. "UNK		
	1 and 2 should Health and Men Iem 27 ie marke sther traumatic		19a. Informant's Name/Relationship (Ty, DAVID T. CHADWICK,				r or Rural Route Number,		
Baltimore,	0 0 = =		20a. Method of Disposition 1 Burial 2 Xremation 3 R 4 Donation 5 Other (Specify)	emoval from State CHE	lace of Disposition (Nemetery, crematory of SAPEAKE CF	ame of cother place) REMATION 0	Date 2 04/01/2006 S	20c. Location - City or TEVENSVILL	Town, State LE, MD
Balt	permit. Pag Department Importent: any njury o		21. Signature of Funeral Service License	efferben	FELLO	and Address of Facility DWS, HELFEN SPEER ROAD,	NBEIN & NEWN CHESTERTOW	AM FUENRAL N, MD 2162	HOME, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	uence of):	terction	cardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	ificate be executed g physicien and ss the burial-transit	edical Examiner	Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	neuce ot):	n hyper	Loopy		175
О. Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use es:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopic			23d. Date of del Month	livery Day Year
ords, P.	w requires thet been signed E should be deta	þ	Part II. Other significant conditions con	tributing to death but not results (acco use contribute to	.
of Vital Records,		Completed					24a. Was ar autops perforg 1 Yes 2	prior to death?	utopsy findings available completion of cause of
Vita	ysicien: The is certificate director, pag	To Be	25. Was case referred to medical examiner?	lospital:	ER/Outpatient 3 [Othor	of Death (Check only one		0.64
ion of	nding Phy th. : After this s funeral d		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho		City)
Division	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined					reet and Number or Ri , State)	ural Route Number,
	To the Hospite within 24 hours To the Funerel completely filled	edical	29a. Certifier 1 Certifying Phys. (Check only one) 2 Medical Exemit	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurre tion and/or investigation	ed at the time, date and on, in my opinion, death	d place, and due to the ca h occurred at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	7.0	2	9c. License number	25	9d. Date signed (Mont	h, Day, Year)
7 1	0		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Print)	100) 十	33	2)2016	21.20
4)	5		FREDERICK	DELBOYNC 32. Rustrar's Signat	002 C	HURCH +	TILLEDO	ALESTED	LOUN MO
	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1 20	06	M Short	8)			

			1 - For State Registrer	State of Ma	rylan		rtment of H		nd Mer		2006	11962
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, La ESTA E. 4a. Facility Name (If not influttion, gi	Ma	e	١. ٨	4b. City Town, o	U C \n	N	Date of Death Month	Day 2006 4c. County of Dea	3. Time of Death
*	Funeral Director			Sex 7. Age 1 □ M 2 🖫 F	(In yrs. 1	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Min. AI	Date of Birth (Month, Day, Y JGUST 2	9. Bir	thplace (State or Foreign buntry) MD
	er death with the Maryland Itams 23a or 28e-f ahow	Director	10a. State MD 10b. County QUEEN A	NNE'S	10c. City	CENT	REVILLE					10d. Inside City Limits 1 ☐ Yes 2 No
	h with th	al Dire	10e. Street and Number 901 CLARKS CO	RNER ROAD			10f. Zip Code	21617		100	J. Citizen of What Co USA	ountry?
9036	rai', or	d by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 XN If Yes, Give Year or Dates:		11	Vas Decedent of H f Yes, specify Cuba Pes 2 No	lispanic Orig an, Mexican, Specify:	in? (Specify Puerto Ric		14. Race - Ame Black, Whi Specify: WH	TE
21215-0036	d within giene. r than "	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4or 5-	+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired SES AID	during most	of working	16	HEALTH CA	•
Maryland	should be filed ind Mental Hygi marked other umatic avent, II	To Be C	17. Father's Name (First, Middle, Las JAMES FLETCHE					MAI	RY ELI	ZABETH		
	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship DONNA CLOUGH/DAU								City or Town, State, EVILLE, M	
Baltimore,	nit. Pages 1 and artment of Healt ortant: If Item 2! injury or other I	00000	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1 0	emetery, cren IRCH HI	sition (Name of natory or other plac LL CEMET	ERY (Date 04/03/	2006	CHURCH HI	CL, MD
Balt	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lice	elfeben		22 F 1	Name and Addre ELLOWS 30 SPEER	ss of Facility HELFEN ROAD	NBEIN CHES	& NEWNA	AM FUNERAL	HOME, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused y one cause on each lin a. CONGE Due to (or as a	9. 5 TI	VE H	EART	FAI	LUR	e	t,	Approximate Interval Between Onset and Death 3 Weeks
68760,		icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a d.	conseq	uence of):	RTER	7 D	(SEF	1 5		ys wares
P.O. Box 68	The law requires that the death certificate be executed ate been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	23c. If yes, outcome of □Live birth 4□Pregnant at 9□ Unknown	2 🗌 Feta	Ideath 3□	Ectopic pregnancy	y			23d. Date of de Month	livery Day Year
	juires that n signed b ıld be deta	þ	Part II. Other significant conditions PULMONARY	FIBRUSI	_	ulting in the u	nderlying cause giv	ven in Part I.		23e. Did toba	<u> </u>	o the cause of death?
Il Records,	The law requir tate hes been s page 2 should	Completed	DEEP VEIN 7	HRUMBOS	15					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
ion of Vital	Attending Physician: The indeath. In death. ector: After this certificate he by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigati	Hospital: 1 Unpaties 28a. Date of Injur (Month, Day		ER/Outpatier 28b. Time of Injury	28c. Injui	ner: 4 🗆 Nur	rsing Home		ce 6 Other (Sperinjury occurred	ecity)
Division	<u>></u> # # = =	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ury - At home, farm, street, factory, office c. (Specify) 28f. Location (Street and Number or Rural Route Number of City or Town, State)					ural Route Number,			
	the Hospitel nin 24 hours a the Funerel I npletely filled	Medical	29a. Certifier i Certifying F (Check only one) 2 Medical Exc	Physicien: To the best of eminer: On the basis of and manner sta	examina	wledge, death	n occurred at the til vestigation, in my o	me, date and opinion, deat	d place, and h occurred	due to the cau at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	Tune	_		29c. Licens	o number	58-	7	1. Date signed (Mon	th, Day, Year) 2006
5) Tm		30. Name and address of person whe	E MD	127	SP	Print)	0 0	Hess	7E1270	W MD	31630
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 3	1 2006 Page 1	r's Signa	ature	Soule					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 06 Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) O6 Month Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name Iff not institution, give street and number) Examiner lanor tor 9. Birthplace (State or Foreign Funeral 1 □ M 2 F Mair Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or itams 23a or 28a-f ahow 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 ia marked othar than "natural", or Itams 23a or 28a-f ahow othar traumatic avant, Ita Medical Examérez must be molified at 1 Yes 2 □ No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2162 Was Decedent Ever in U.S. Armed Forces 1 Tyes 2 No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 Married 1 Never Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Glaves Williams Viola 1hom OMIC 19b. Mailing Address (Street and Number of Rural 9834 ECRSON Ros J Method of Disposition 1 Burial 2 ☐ Cremation 3 □Removal from State injury or 4 □ Donation 5 □ Other (Specify) 21. Sig Gure of Full eral Service Licensee any in Appromate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Rospiratore Pnysician /Medical Due to (or as a consequence of): **Examiner** ueum oni 9 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be execu Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 Physiclan/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Completed by PAD ASHDI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CVA & BHeins pavale 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2□ No 2 No 1 Tyes To the Hospital or Attending Physician: the fumeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No P 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural r death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To tha Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 50996

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) MAR 28

who completed cause of death (Item 23a) (Type, Print) MD

2006

100 F 32. Registres Signature

Physician /Medical Examiner

Examiner

Be Completed by Physician/Medical

2

Certification:

Medical

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

10a, State

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Deperment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Madical Examiner must be notified at once.

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attending physicien end for use as the burial-transit signed by the a After

To the Hospitei or Attending Physicien: The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital within 24 hours efter death.

To the Funeral Director: All completely filled in by the fu

MJL ITIVA State Guy A. Calligan IV, son 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ⋈ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Z Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 XNatural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29c. License number 29b. Signature and title of certifier DO0 59919 30. Name and ad ress of person who complet cause of death (Item 23a) (Type, Print) Glan Burnie 32. Registrar's Signature 31. Date filed (Month, Day, Year) APR 03 2006 ORIGINAL

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

1 2006

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State of Maryland /	Department of Health and M	ental Hygie

Coakley, Bernard		State	of Maryland	/ Department	of Health and	Mental Hy	giene			
	1- For State Registrar			Certificate	of Death		Reg No	2006	11966	j
Physician/	Decedent's Name (Fire particular of the par	rst, Middle,Last))				2. Date of Death		3. Time of Death	
Medical Examiner	Bernard	J.	Coakley	II			April 5, 2006	Year	8:20	
	4a. Facility Name (if not 16228 Frederic		street and number)	4b. City, Town, or L Gaithersburg			c. County of Death Montgomery		
Funeral	5. Social Security Numb	er 6. Sex	x 7. Ac	ge (In yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	B Date of Birth (MM	M/DD/YYYY) 9. Birl	thplace (State or Foreign	

Directo

permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Estatiner must be notified at once. Baltimore, MD 21215-0036 Physiciai /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerab Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

4.5 Sound Security Number 16. Sex 17. Age in yes last similary 18. Sex 18. Sex 19. Sex 17. Age in yes last similary 18. Sex 19	Social Security Number S. Sex 7. Age (in yrs. last shirthcarp) Hurber 1/are Hurber 2/are Hurber 1/a	Bernard J.		II				Month April 5, 200	Day Ye.		3. Time of Death 8:20	
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Sharon I. Middledorf - Sister 20b Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Sharon I. Middledorf - Sister 20b Flace of Destiny Cir. Annapolis, Md 21409 20b Rate of Despation (Name of Cameley, Carenatory or Other place) 21 Sparial 2 Xi Ceremation 3 Removal from State 4 Donation 5 Other Space (Fraction of Destiny Carenatory or Other place) 21 Signated of Fungus Service Licensee 22a Sparial Free the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory affects and sease or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory affects and sease or complications each line. Methadone and alprazolam intoxication Due to (or as a consequence of): AMENDED Item#23a, 27, 28a-f, pertYe, C854, 4/19/06 TT IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 1 Ves 2 No 9 Contributing to death but not resulting in the underlying cause given in Part I. 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examin	Sharon J., Middledorf - Sister 20 Memory of Destin Virye, Pirit) Sharon J., Middledorf - Sister 20 Memory of Destin Virye as a consequence of Virye of Same of Destin Viryers and Sam	17. Father's Name (First, Midd	le. Last)			18.Mother	's Name (F	First, Middle, Ma	aiden Surname	e)		
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4 Donation 5 Other Specify: Kalas Crematory 4/7/2007 Edgewater, MD 21. Signality of Funsal Septing Lonsee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 229. The first the disease, or complications that caused the death. Do not enter the mode of dying, such as addisor or respiratory afrest shock, or heart of the first production resulting in death Do not enter the mode of dying, such as addisor or respiratory afrest shock, or heart of the first production of the fi	A Donation S Other Specify Salas Crematory A A A A A				position (Name of	y Cir.	, An	napolis Date	Md 2°	1409 - City or T	own, State	
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George P. Kalas Fruneral Hottle, P.A. 29a. 1941. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory direct, shock, or heart force. It is only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause. List (Disease or injury that initiated events resulting in death) Last AMENDED LIST (Press, outcome of pregnancy and pregnant in the past 12 months? If FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	George P. Kallas Frueral Horle, P.A. 293. Solomons Island Rd., Edgewater, offure List only one cause on each line. When the death Do not enfer the mode of dying, such as cardiac or respiratory strest, shock or heart of condition resulting in death) Due to (or as a consequence of): ### Wethadone and alprazolam intoxication Due to (or as a consequence of): Maintenance M		, ,	22	Name and Addre	ess of Facility	v				110	
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Methadone and alprazolam intoxication Sequentially list conditions, if any, leading to immediate Cause (Disease Ferred to medical examiner? IF FEMALE: 230. UnyPENDED IF FEMALE: 231. UnyPENDED IF FEMALE: 232. UnyPENDED IF FEMALE: 233. UnyPENDED IF FEMALE: IF F	Between Onse Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due	23a. Par I. Enter the disease.	or complications that cause	d the death. Do not ente	2973 Solo	mons]	Islandardardardardardardardardardardardardard	d Rd., espiratory arres	Edgewa1	ter,		
Wind West decedent pregnant in the past 12 months?	Were autopsy findings awariner? Lower of Death (Check only one) Lower one) Lower of Death (Check only one) Lower of Death (Check only one) Lower of Death (Check only one) Lower of Death (Check only one) Lower one)	if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiated	figure (Disease or injury that initiated Due to (or as a consequence of):									
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1	24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1	23b. Was decedent pregnant in past 12 months?	1 Live birth 4 Pregnant	2		3 Ectopi	c pregnanc	cy			ay Year	
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alr Wonica - Williams	30. Name and address of person who completed cause of death (Item 23a)	29b Signature and title of cert			29c. Lice	nse number			29d. Date sigr	ned (Mont	h, Day, Year)	
		Patri a	ronica -	Polle-	0.0	C.M.E.			April 6, 20	06		

State Registrar



			For State Registrar	State of N	/aryland		artment			and M	_	giene Reg. No.	06	11967
			Decedent's Name (First, Middle, Last)						•		2. Date of De Month	ath Day	Year	3. Time of Death
F	hysici: Medic/		DORIS	Ε.	CU	RTIN					APRIL	2,	2006	11:50 A ^M
E	Examin		4a. Facility Name (If not institution, give sa	reet and numbe	or)		4b. City, 1	Town, or	Location o	f Death		4c. Cc	unty of Death	
			SACRED HEART HOM						rsvil					GEORGES
	uneral		5. Social Security Number 6. Sex	M 2X1F 7.7	Age (In yrs. Ia	ist birthday) Yrs.	If Under Months	Days	If Under :	Min.	8. Date of Birt (Month, Da	v. Year)	Coui	place (State or Foreign
Di	rector		579-20-2850		83						OCT. 12	2, 192	ZZ WAS	HÍNGTON, DC
rland	Mo Ti		10a. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
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h the	1.28g	Director	10e. Street and Number				10f. Zip	Code				10g. Citizer	of What Cou	ntry?
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r dee	ema L	Funeral	11. Marital Status 1	Was Deceder Armed Force	s?	3. 13.	Was Deced	ent of His	spanic Ori n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
s afte	l o l	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 If Yes, Give			1 □ Yes 2	□ No	Specify:			S	oecify: WHI	TT D
G Z IZ I 3-0030 filled within 72 hours after deeth with the Maryland Hygiene.	tural at Ex		15. Decedent's Educ	Year or Dates	s:	16a Dece	dent's Usua	l Occupa	ition			16b. Kind	of Business/In	
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d be filed ontal Hyg	othe vant,	0	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	e (First, Middle,	Maiden Su	татө)	
uld be	rked tic e	To B	RICHARD	V. C	OOLEY					ISAE	BEL HOV	WARD	THOMAS	
and Men	is me		19a. Informant's Name/Relationship (Type	e, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	or Or Rura	al Route Numb	er, City or T	own, State, Zip	o Code)
and and	n 27 iar tr		DOROTHY M. MASON	/DAUGHT					S CIR	-	COWSON,			
ore of H	If Itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from Sta	CO	ace of Dispo metery, crei	nsition (Name matory or ot	e of her place	9)		Date	20c. Loca	tion - City or To	own, State
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permit. Pages Department of	Important: If Itam 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic evant, the Madical Examination into the motified at once.		21. Signature of Funeral Service License	luca	D MOO	091 S	P. Name and HAMBEI 801 CI	Addres RS FI LEVE	s of Facilit UNERA LAND	L HC	ME & CI	REMATO	RIUM,P MD. 2	.A. 0737
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that cause cause on each	sed the death.	. Do not ent	er the mode	of dying	g, such as	cardiac d	or respiratory a	rrest,		Approximate Interval Between
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2	sit.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Clusters of what?											
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death cer	atter for u	Physician/M	in the past 12 months? 1 \(\sumset \text{Yes} 2 \sumset \text{XNo} \)		i 2 □ Fetal tat time of de		∃Ectopic pro ∃Other <i>(sp</i> e						Month	Day Year
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ecords, P.O.	signed by the a I be detached f	by P	Part II. Other significant conditions con	tributing to deat	h but not resu	Iting in the u	nderlying ca	ause give	n in Part I		23e. Did t	obacco use		he cause of death?
rds quires	been sig should b							-			1 🗆	Yes 2 🗆	Vo 3∭ Prol	bably 4 Dunknown
PCO law rec	2 sho	piet									24a. Was		24b. Were auto	opsy findings available ompletion of cause of
Ĭ ĝ	بر و و	Completed									perfo	rmed?	death? 1 ☐ Yes	
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OT VITA Phyaician:	this certific ral director,	To	1 ☐ Yes 2 🙀 No		atient 2 🗆 E	ER/Outpatie			140	ırsing Ho	me 5□Resi	dence 6 [Other (Speci	fy)
⊑ 5°	fter		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time a Injury	- 1	8c. Injury Work	(?		28d. Describe	how injury o	occurred	
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DIVISION I or Attending efter death.	Direct in by	Certification;	4 ☐ Homicide determined	28e. Place of building,	Injury - At hor , etc. (Specify)	me, farm, st	reet, factory	, office			City or To		vumber or Hur	al Route Number,
Hospital	filled		29a. Certifier 1 ☐ Certifying Phys	ician: To the be	est of my know	wledge, deat	h occurred	at the tim	ne, date an	d place	and due to the	cause(s) ar	nd manner as	stated.
B Hos	To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examin		s of examinati									
To the within 2	ro th	Me	29b. Signature and title of certifier	6					number				signed (Month,	
->	0		> born	(1)				D 5	1520	0		04-	03-20	006
	et		30. Name and address of person who co	mpleted cause of						-				
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JC 06-02189 Jerri A. Deavers

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier

OI	Maryland /	Department	01.1	Health	and	IVI:
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Funeral Director

with the Maryland en "naturel", or Itema 23s or 28s-f show Medical Examiner must be notified at death v Pages 1 and 2 ment of Health a ant: if Item 27 is ury or other tree permit. Page Department of Important: If any Injury or once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

> physician and s the burial-transit attending pl signed by the a s certificate has b lirector, page 2 s : After this certification funeral director, death.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 30, 2006 Jerri Ann Deavers March 03:32 A M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death University Of Maryland Shock Trauma Baltimore City Il Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🖾 F 223-11-8791 August 16, 1964 Wash., DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Gambrills 1 ☑ Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 912 Gunnison Ct. 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2½ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Realtor Real Estate Yr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Thomas Anderson Jackie Lou Rardin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas M. Deavers, Sr./ Spouse 912 Gunnison Ct. Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery April 3, 2006 Brentwood, MD 20a. Method ol Disposition 20c. Location - City or Town, State 1 DBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy Bowie, MD 20715 KBY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mult; ini ple Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated according to the control of the c Due to (or as a consequence ol): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ Yes 2□ No 28d. Describe how injury occurred which that 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 1 Natural 5 Pending investigation Driver of motor which that collided with another motor which 1 Yes 2 No 3=30-06 1:59 A 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Waugh Chapel Rd 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) within 24 hours after de To the Funerel Directo completely filled in by t 4 Homicide Road ect Road 3 Odenton ms 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number he mil O.C.M.E. March 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 LING LJ

State Registrar

31. Date filed (Month, Day, Year)

MAR 3 1 2006

. Registrar's Signature...

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician REBECCA ADAMS DIETRICH 2006 MAR 26 2:58 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA 8. Date of Birth (Month, Day, You DEC. 28, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** , 1918 MASSACHUSETTS 1 ☐ M 2 🂢 F Months 87 Director 010-24-7421 Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location in than "naturel", or Items 23s or 28s-f show the Middles Examiner count be notified at Yes 2 □ No Director WASHINGTON D.C. NONE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4472 UPTON ST. N.W. 20016 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1X Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. NAVY DEFENSE other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be in nent of Health and Mental suit: If Item 27 is marked o ဥ **GEORGE** S. DIETRICH GENTE Α. BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCESCA DAHLGREN/FRIEND 5111 MASSACHUSETTS AVE. N.W., WASHINGTON, D.C.20016 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Injury or o permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHAMBERS CREMATORY APR. 5, 2006 RIVERDALE, MD. 21. Signature of Funeral Service Censee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. - Chamberal M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner MULTI ORGAN FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran HYPERNATREMIA that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Year 4 Pregnant at time of death 5 Other (specify) cete has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo Hospital: 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending after death. 1 Tyes 2 No investigation 2 ☐ Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) entire manner stated. 29a. Certifier Medicai within 2 To the 29b. Signature and 29c. License number 29d. Date signed (Month, Qay, Year) 0116017107 (VA) NATIONAL NAVAL MEDICAL completed cause of death (Item 83a) (Type, Print) CENTER 30. Name and address of perso BETHESDA MD 20889-5600 SUMMERLEE USN ROBERT J. LT MC

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR

0 3 2006

2. Registrar's Signature

			1 - For State of Maryland / Dep	artment of Health and Martificate of Death		ene	97
	Dhysisi		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medic		Philip M. Davenport			31, 2006	5:45 a M
	Examin	er	4a. Facility Name (If not institution, give street and number) 3405 Kenilworth Drive	4b. City, Town, or Location of Death Chevy Chase		4c. County of Dea	gomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	-	8. Date of Birth		thplace (State or Foreign
	Director		579-10-5311 № 2□F 90 Yrs.	Months Days Hours Min.	Dec. 21,	rear) Co	hington, DC
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	conting			10d. Inside City Limits
	Maryla f sho	o					1 ☐ Yes 2 No
	the N	rect	Maryland Montgomery Chevy 10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	puntry?
	h with	a D	3405 Kenilworth Drive	20815		USA	,
960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28a-f show any injury or other traumatic event. It a Modical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes Z No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Whi	te, etc.
5-0	72 h	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ing 1	6b. Kind of Business	/Industry
12	within ane. than '	ldmo	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) ficer	1	J.S. Forei	gn Service
2	filed Hygid other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name			9
ılan	uld be dental rked tic ev	To B	Royal William Davenport	Alice Mo	Clellan	Purinton	
Maryland 21215-0036	nd 2 sho aith and A 27 is ma r trauma			ing Address (Street and Number or Aura Kenilworth Drive			
Baltimore,	ages 1 a ant of Heart y or other		1 Magnial 2 Cremation 3 Hemoval from State	osition (Name of matory or other place) April eaven Cemetery 200		oc. Location - City or	Town, State
	pertme portan y injur			2a Margago Address of Falliyns I			iig, iialyluii
ö —	Per E	0	Jans 2 Dog 50	00 University Blvd,	W, Silv	er Spring	, MD 20901
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
de s	Priysician		Immediate Cause (Final disease or condition resulting in death)				2 Weeks
	/Medical Examiner		Due to (or as a consequence of):	cardievascula	Jin	dan	1150118
	7	Jer	Sacus niledy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	carati vastulo	W 2156	case	7 2015
	cuted nd ransit	Examiner	that initiated eventsC.				•
ŠĊ,	cate be executed obysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):				
09/8	cate b physic the b	dical	d				
o O	eath certific attending p I for use as	Physiclan/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	liven.
ñ	death a atter d for u	iclar	in the past 12 months? Use 1 Ves 2 No 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year
J.	at the de by the a tached i	hys	9 Unknown 9 Unknown				
Hecords, 1	ires tha	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	1	the cause of death?
000	e law requ has been je 2 should	Completed			24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
		Com			performe	death? No 1 ☐ Yes	\ /
VItal	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
0	Phys this al di	- To	1 Inpatient 2 EN/Outpatie		ne 5 Nesiden 28d. Describe how	ce 6 Other (Spec	cify)
0	nding th. : Afte. e fune	tlon	27. Manper of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	-04. 20001120 11011	injury occurred	
DIVISION	l or Atter after dea Director I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a section, in my opinion, death occurred	and due to the cau	se(s) and manner as and place, and due	s stated. to the cause(s)
	o the vithin o the omple	Mec	one) and manner stated. 29b. Signature and title of certifier /	29c. License number	290	I. Date signed (Monti	h, Day, Year)
			I Patricia Tomsko May, Mist	D51916		March:	31, 200E
	25		30. Name and address of person who completed cause of death (Mem 23a) (Type Patricial OMSKO NAY)	Print) / Pike G-	100. Roc	kville.	MD 20852
	Sta		31. Date filed (Month, Day, Year) APR 0.3. 2006	all i	/	11-/-	10
	Registr	-11	APR 0 3 2006				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 643 2006 /Medical 46. Cjty Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth Month, Day, Year) JUNE 29, 1946 If Under 1 7. Age (In vrs. last birthdav) Year Birthplace (State or Foreign Country)
 T T 5. Social Security Number 6 Sex **Funeral** Days Months Hours 1 □XM 2 □ F 59 139-40-5195 NJ Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28e-f ehow other traumatic event, the Medical Exerts at most by notified at COLLINGSWOOD 1 XYes 2 No NJCAMDEN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 08108 USA 448 CENTER STREET 238 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 ò If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Flementary/Secondary (0-12) College (1-4or 5+) ENGINEERING ENGINEER 12 18. Mother's Name (First, Middle, Maiden Surname) RUTH B. DUNN 17. Father's Name (First, Middle, Last) Be GRANVILLE H. DAVIS, SR. Pages 1 and 2 should be ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 NORTH RIDING DR., CHERRY HILL, NJ 08003 MALCOLM FOSTER/EXECUTOR item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of H Ir portant: if ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BETHEL CEMETERY 04/07/2006 HURFVILLE, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME
130 SPEEK ROAD, CHESTERTOWN, ML 21620 21. Signature of Funeral Service Licensee Tack of Gleffenbein FELLOWS, HELFENBEIN AND NEW 130 SPEEK ROAD, CHESTERTOWN, 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anaplastic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the all id be detached for P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, embs/15m 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Wasan certificete has t performed? 1 ☐ Yes 2 X No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death |Check only one Other: Impatient 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After th 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 ∏No the Funeral Director; A pletely filled in by the funeral price to the funeral price filled in by the funeral price for the form of the for investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

6602

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3/0

		1 - For State of Maryland / Department Certification	e of Death	Reg. No.
Phys	ician	1. Decedent's Name (First, Middle, Last)	2. Date Monti	of Death h Day Year
	dical	CHARLES WILLIAM DONOWAY, JR.	03	29 2006 9:38 A M
Exan	niner		Town, or Location of Death	4c. County of Death
		100 Billimook Billy	LISBURY	WICOMICO
Funer: Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	Days Hours Min. (Mont	of Birth h, Day, Year) 20-1950 9. Birthplace (State or Foreign Country) SALISBURY, MD.
		Usual Residence of Decedent	02-2	DALIBBORI, MD.
rylanc how		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
B Mai	çţ	MD WICOMICO SALISBURY		1 ☐ Yes 2 ☒ No
ith th	Director	10e. Street and Number 10f. Zij	Code	10g. Citizen of What Country?
ath w	60	166 SHAMROCK DRIVE	21804	USA
er de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces?	dent of Hispanic Origin? (Specify Yes cify Cuban, Mexican, Puerto Rican, etc	or No- 2.) 14. Race - American Indian, Black, White, etc.
rs aft	by F		2 No Specify:	Specify: WHITE
5-UU30 72 hours after death with the Maryland naturel; or Itams 23a or 28a-f ehow dical Examinating at all and			al Occupation	16b. Kind of Business/Industry
Pin 7	Completed	(Specify only highest grade completed) (Give kind of we life. DO NOT L	ork done during most of working se retired)	
TIC Z IZ IS Se filed within 7 al Hygiene. 1 other than "n went, Ita Med	S I	12 MASTER M	ECHANIC	MANUFACTURER
ytand ould be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	iddle, Maiden Sumame)
ACT YEAR 2 should be 2 should be 1 and Mental 1 is marked raumatic ev	2		VIOLA MASON	
If E, INITITY INITY A LAID-UUSO 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. item 27 is marked other than "naturel", or items 23a or 28e-f ehow other traumatic event, I'te Medical Examina in the Intitlied at		0/0/0 7477		lumber, City or Town, State, Zip Code) LLE, MARYLAND 21850
e, M 1 and 2 Health em 27 l		RICK PROUSE - SON 34360 PARK 20a. Method of Disposition 20b. Place of Disposition (Na		20c. Location - City or Town, State
To the state of th		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	other place)	
DESILITION SETTING SETING SETTING SETTING SETTING SET			M. GDNS 04-01-200	FUNERAL HOME, INC.
baitimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other	DUCE	1. 10/1/2 01/1/1/1		LISBURY, MARYLAND 21804
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the more		ory arrest. Approximate
Dhysisis		shock, or heart failure. List only one cause on each line.	a Month. Au	Interval Between Onset and Death
Physicia /Medica		disease or condition resulting in death) Due to (or as a consequence of):	annaup	11 1110
Examine	er		·	
n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		
and trans	Examiner	Cause (Disease or injury that initiated events c		
ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):		
I TECOTOS, P.O. BOX 08/00, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d		-
certiff certiff ding	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
BOX death cer attendin d for use	clar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		Month Day Year
of the	hysi	9 Unknown		
COLOS, P.O. BOX OR wrequires that the death certifies been signed by the attending ph should be detached for use as to	by P		eause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
w requires to been signed should be a				1 Yes 2 No 3 Probably 4 Unknown
law re	Completed			Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
The The late has bage	E O		101	performed? death?
on or vital ned ding Physicien: The lav h. After this certificate has funeral director, page 2.	Be	25. Was case referred to medical examiner?	26. Place of Death (Check	
Physic Physic rthis ce ral dire	2	1 Yes 27 No Hospital: 1 Inpatient 2 ER/Outpatient 3 Do		Residence 6 Other (Specify)
ing P Witer t	on:		Work?	ribe how injury occurred
VISION Attending ar death. ector: Afte by the fune	cat	2 Accident investigation M	1 Yes 2 No	. (2)
or At or At or At or At or At or At or At or At or At or At	Certification:	4 Homicide 4 Homicide 4 Be. Place of Injury - At home, farm, street, factor building, etc. (Specify)	y, office 28f. Locat City of	ion (Street and Number or Rural Route Number, or Town, State)
DIVISION OI VILA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred	at the time, date and place, and due to	o the cause(s) and manner as stated
e Hos 24 h e Fun etely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
To th within Fo th	Me	29b. Signature and title acceptation 29	c. License number	29d. Date signed (Month, Day, Year)
/.	2	· VICINEMO	0 20507	3/30/06
12 114		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		0.0
I			uce St SALLS	anny 1000 21801
	State	31. Date filed (Month, Day, Year) APR 0.3 2006		

			1 - State of Ma		artment of Hea		ental Hygie	2006	11974
	Physic /Medi		1. Decedent's Name (First, Middle, Last) The M. Davi	5			2. Date of Death Month 3/30	12006	3:13 PM
	Exami	ner		Spital	4b. City, Town, or Lo	'n		4c. County of D	ester
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 🔀 F 7. Age 1 ☐ M 2 🔀 F 8. Sex 1 ☐ M 2 🔀 F 8. Sex 1 ☐ M 2 🔀 F 8. Sex 1 ☐ M 2 🖼 F 8. Sex 1 ☐ M 2 О ☐ M 2 О ☐ M 2 О ☐ M 2 О ☐ M 2 О ☐ M 2 О ☐ M 2 О ☐ M 2 O ☐ M 2	(In yrs. last birthday) 85 Yrs.		Hours Min.	B. Date of Birth (Month, Day, Ye SEPT. 6,	1920 ^{9.}	Birthplace (State or Foreign Country) MARYLAND
	ith the Maryland or 28a-f show	or	10a. State 10b. County MARYLAND WORCESTER	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	vith the Maryla or 28a-f show	Directo	10e. Street and Number	OOLAN	10f. Zip Code		10g.	Citizen of What	Country?
	eath w		12234 GREEN RIDGE LANE 11. Marital Status 12. Was Decedent E	iver in 11 S 12	21842		4. Vas as Na	USA	
950	If Z 12.15-0050 filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or iteme 23a or 28a-f show ont, the Marifial Examinational be multiled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	0	Was Decedent of Hispa ff Yes, specify Cuban, M 1 ☐ Yes 2 No S		ity Yes or No- ican, etc.)	Black, W	merican Indian, hite, etc. WHITE
21215-0036	hin 72 hours b. n. "natural",	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	7 16b	. Kind of Busine	ss/Industry
	be tiled within tal Hygiene.	Com	8	,	HOMEMAKER			OWN HO	OME
30106 Manyland	⊕ a is p >	To Be	17. Father's Name (First, Middle, Last) JOHN HENRY	MITCHELL	18.	. Mother's Name (aCURTS	
	- 2=2	i	19a. Informant's Name/Relationship (Type, Print) SHARON PARSONS/NIECE		ng Address (Street and GREEN RID				e, Zip Code) RYLAND 21842
Seltimore			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	1	matory`or other place)	Da:		Location - City	
CC	Definit. Page Department of Important: If Important: If only injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		CEMETERY 2. Name and Address of	4/3/0	06	GUMBORO	, DELAWARE
00	0 88888		Charles W Henry		STINGS FUN			=	
	Physician (Madical		23a. Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each fine firm mediate Cause (Final disease or condition resulting in death)	He death. Do not ent	ter the mode of dying, si	uch as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
20	/Medical Examiner		Due to (or as a	monta					days
0	cuted ansit	Examiner	Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	nonsaquence of)					
9-60-8750	ate be executed hysicien and the burial-transit		requiting in death) Leat	consequence of):					
ď	ntificate ng physi	Medic	IF FEMALE:			25.			
662 882	The County, T.C. DON Of The law requires that the death certific tie has been signed by the attending page 2 should be detached for use as it.	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Petaf death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of a	delivery Day Year
20 7 L	equires that	d by Ph	Part II. Other significant conditions contributing to death but CO1925 TIVE heart fa		nderlying cause given in	n Part I.		_	to the cause of death? Probably 4 Unknown
1 0 -	ne law req has beer ge 2 shou	Completed by	atrial fibrillation				24a. Was an autopsy performed	24b. Were prior to death	autopsy findings available to completion of cause of
the the		Be Co	25. Was case referred to medical		26	. Pface of Death	1□ Yes 2□		
1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 ×	Physici Physici this cer al direc	P	examiner? 1 ☐ Yes 2 ☐ No Hospitaf: 1 Lenpatien		nt 3 DOA Other:	4 ☐ Nursing Home	C	6 □Other (S	pecify)
Division	anding sath. or: After he fune	Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of finium (Month, Day)	Year) 28b. Time of Injury	Work?	2 No	d. Describe how in	n _f ury occurred	
) ivi	tal or Att	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of fnjur building, etc.	y - At home, farm, str (Specify)	eet, factory, office	28	f. Location (Street City or Town, St	and Number or late)	Rural Route Number,
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	examination and/or inv	h occurred at the time, divestigation, in my opinion	date and place, and on, death occurred	d due to the cause at the time, date	e(s) and manner and place, and d	as stated. tue to the cause(s)
	within To t	Σ	29b. Signature and title of certifier	00.0		mber (DE)		Date signed (Mo	onth, Day, Year)
	/ nol		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type		06795		-3106	
1) III		KRISTINE BRITING MD 12	09 CUAST	AL HOHW	AY, EL	rucie 1	SLAND	DE 19944
	Sta Registr		31. Date filed (Month, Day, Year) 32. Fegistrar APR 0 3 2006	's Signature	parte				, DE 19944

06-02416	
Dennis, Betty	

Physician Medical Examine

> Funeral Director

> > any

permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, MD 21215-0036

_	State of Marylan	d / Departme	ent of	Black Indeli		tvaiene				200 000
1- For State	state of Marylan	Certifica			Michilan	rygiciic		200		1197
Registrar 1. Decedent's Name (First, Mid	dle Last)	Continue	ate or	Death		2. Date of D	Reg. No. eath		3	Time of Death
, ,						Month April 8,	Day	Year	J.	18:00
BETTY JANE 4a. Facility Name (if not institut)		er)	41	o. City, Town, or Lo	ocation of Dear			c. County of E	Death	
8523 Ocean Gatewa	· -	o.,		Easton				Talbot		
5. Social Security Number	6. Sex 7.	Age (In yrs. last birtl	hdav)	If Under 1 Year	If Under 24H	rs. 8. Date of	Birth (MM	/DD/YYYY) 9	Birthpl	ace (State or Fo
247-86-6590	1 M 2 X F	57	Yrs.	Months Days	Hours M	n. JAN	17,	1949	Countr	INOIS
Usual Residence of Decedent		lee 0: =								
10a. State 10b. County	у	10c. City, Town								d. Inside City Lir
MD	TALBOT	EA	STON				,		_ ! '	Yes 2
10e. Street and Number				10f. Zip Code			10g. Cit	izen of What	Country	?
700 PORT ST.	. UNIT 350			2160	1				USA	
11. Marital Status 1 Never Married 2	Married 12. Was Deceded Armed Force 1 Yes Divorced If Yes, Give Year		If Ye	Decedent of Hispa s, specify Cuban, N	Mexican, Puerl		No-	14. Race - A White, e	merican tc.	Indian, Black,
	or Dates:	completed) 16a [s Usual Occupation		work done	16h	Kind of Busin	WHLI	
 Decedent's Education (Sp Elementary/Secondary (0-12 		during			,	HOIR GOILE	100.	and or bushi	ooorn IUL	, va y
		J. J.,		orking life, DO NO				ுரை தாரு ்	COM	TO SEE STEEL STOP
12 17. Father's Name (First, Middl	4 (ast)		2001	AL WORKE		ne (First, Middl			GUVE	RNMENT
						F. THO		,,		
DR. J.M. DEN		196	Mailing	Address (Street a				ity or Town	State 7i	n Code)
23a. Part I. Enter the disease, a failure. List only one caus	se on each line.	ed the death. Do no	200	LOWS, HE S. HARR mode of dying, su	ISON S'	r easto	N. M	D 2160	1	
Immodiate Course (Elect di		_		 11.46.4 			arrest, sin	ock, or near		Between Onset
Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a co	ng Intoxicat	cion (Oxycdone ar			arrest, sir	ock, or near		Approximate Inte Between Onset a Death
or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	Due to (or as a co	nsequence of):	cion (Oxycdone ar			arrest, Shi	ock, or neart		Between Onset
or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a co b. Due to (or as a co se	nsequence of):	cion (Oxycdone ar			arrest, sin	ock, or neart		Between Onset
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or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las X UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant conditions are usually used to medic examiner? 1 Yes 2 No 25. Was case referred to medic examiner? 1 Yes 2 No	Due to (or as a color b. Due to (or as a color	insequence of): insequence of): insequence of): item#23a,27, come of pregnancy t at time of death eath but not resulting	,28a-f	perME, g855 al death 3 er (Specify) aderlying cause give 26. Place c 3 DOA or giury 28c. Injury	nd Tramad 5,5/1/06 Ectopic pregulation of Death (Check ther Nurse	23e. Did 1 24a. Wau pe 1 7 Ye k only one) ing Home 5 28d. Descrii	d tobacco Yes 2 as an topsy rformed? s 2 Residue	d. Date of de Month use contribu No 3 24b. We prio dea 1	livery Day te to the Probable re autop: r to com th? Yes Other: So	Year cause of death' y 4 1 1 unkno

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death.

To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the funeral director. page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature Zabiullah Ali, M.D. Assistant Medical Examiner

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

April 9, 2006

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

State Registrar 31. Date filed (Month, Day, Year) APR 1 7 2006



			1 - For State Registrar	State of Maryl		artmen rtificate			-	giene Reg. No.	06	11977	
	Physic	an	Decedent's Name (First, Middle, Last						2. Date of De Month		Yeer	3. Time of Death	Ī
10 S 14	/Medi Examir	cal	Doris Martin El 4a. Facility Name (If not institution, give Pen/NSIIA Legional		W	4b. City,		Location of Deat	March		unty of Death	1810	<i>A</i>
	Funeral Director		5. Social Security Number 6. Se		yrs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da 5-22-1	th 926	Cou	olace (State or Foreig ntry) ONSIN	חק
	e Maryland la-f ehow	ctor	10a. State 10b. County Worceste		City, Town or Lo						1	0d. Inside City Limit MXYes 2 □ N	
	with the	Director	10e. Street and Number	D. D.d		10f. Zip	Code 1842				of What Cour	ntry?	
036	be tiled within 72 hours after death with the Maryland Hygiene. All Hygiene de ther than "natural", or Iteme 23e or 28e-f ehow de ther than "natural", or Iteme 23e or 28e-f ehow event, the Madical Examinat must be millied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	1		lent of His		pecify Yes or No o Rican, etc.)		Race - Americ Black, White, ecify: Whi	etc.	
21215-0036	i within 72 ho jene. r than "natur itte Wedical I	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+)	16a. Deced (Give life. Owner		k done di e retired)	tion uring most of wor	king	16b. Kind o	of Business/In	dustry	_
Maryland		To Be C	17. Father's Name (First, Middle, Last) Leo Martin			9601		18. Mother's Nar Julia M	ne (First, Middle,				
	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (7. Charles E. Elliot 20a. Method of Disposition	t (husband)		1 Gof	1 Cou		nal Route Number Ocean	City,		1842	
altimore,	Page ment o ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crem Sunset Mo	matory`or of emoria	herplace al Pa	ark 4-5	-2006	Berli	n, Mary	yland	
g	Departit. Departit Importit any inj		21. Signature of Funeral Service Licen	elebal.		108	Wil:	iam St.	e Burbaq , Berlin	ge Fun n, Md.	eral H 21811	ome	
1	Physician /Medical		23a. Part1. Enter the disease for comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the dine cause on each line. Bue to (or as a cons					or respiratory ar	rest,		Approximate Interval Between Onset and Death	_
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	λ.				-				_
00/0	certificate be executed rding physicien and use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	sequence of):								
O. DOX of	certi nding use a	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of	etal death 3 [Ectopic pre					Date of delive Month	ry Day Year	
cords, F.	requires that the death een signed by the atter hould be detached for u	9	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying ca	use given	in Part I.		obacco use c		e cause of death?	
ם ב	Ine la ete has page 2	Completed							24a. Was autop perfor	sy	prior to con death?	osy findings available inpletion of cause of	Э
200	certific irector,	Be	25. Was case referred to medical examiner?	Hospital:			Othor		th (Check only or	ne)			_
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	urs after de rel Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	ecity)				28f. Location (S City or Tow	n, State)			_
:	Prosper	Medicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exam and manner stated.	nowledge, death ination and/or inv	occurred a estigation, i	t the time in my opir	date and place, nion, death occur	and due to the c red at the time, c	ause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)	
)	withir To th comp	Me	29b. Signature and title of certifier	ompleted cause of death (III) when the same and the same		29c.	License r	S27.	2	29d. Date sig	ned (Month, D	Day, Year) 6:30 P	34
Z	74		30. Name and address of person who g	empleted cause of death (III	tem 23a) (Type, F	Print)	100	F. Cari	0115+	Solie	hum	mD - 2/0	0)
	Sta Registra	.6	31. Date filed (Month, Day, Year) APR 0 4 20	32. Degistrar's Sig	nature	المالية	g or Lr				20191	1112 NISC	-/

			1 - For Stete Registrer	State of Ma	aryland / Dep <i>Ce</i>	artment of I		R	eg.:No.0 0 6	11978
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Gladys 4a. Facility Name (If not institution, give s	treet and number)	Flury	4b. City, Town, c	or Location of Deat	2. Date of Dear Month Apr 12,	Day Ye	4:30 am ^M
	Funeral	iei	Cumberland Nursin 5. Social Security Number 6. Sex	ng Home	e (In yrs. last birthday	Cumbe	rland		Allegan	
	Director ≥		147-12-2085 Usual Residence of Decedent 10a. State 10b. County	M 2) (F	90 Yrs.		Tiodia William	8. Date of Birth (Month, Day, Apr 23	1915	NJ 10d. Inside City Limits
	the Maryl 28a-f sho	Funeral Director	MD Allegan	y 	Cum	berland		1	0g. Citizen of What	1 ☐ Yes 2 ☐ No
	th with	al DI	701 Furnace Street	Apt. 333			21502		USA	•
9600	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28e-f show te Mauleal Examiret must be notitied at	b	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	Was Decedent of HIFYes, specify Cub	Specify:		Specify:	merican Indian, /hite, etc. vhite
Maryland 21215-0036		Completed	15. Decedent's Educine (Specify only highest grade		(Give	edent's Usual Occup a kind of work done DO NOT use retire maker	pation during most of wo d)	rking	16b. Kind of Busine OWN home	
land;		To Be C	17. Father's Name (First, Middle, Last) unknown Hemple)				me (First, Middle, F ris Helwig	Maiden Surname)	
, Mary	d 2 shu th and 7 Is m traum		19a. Informant's Name/Relationship (Ty) Edward May	grand	dson P.C	ing Address (Street . Box 26	and Number or Ru	oral Route Number Oldtov	City or Town, Stat	e, Zip Code) MD 21555
Baltimore,	Sorie		20a. Method of Disposition 1 ☐ Burial 2 ☐ Sremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		osition (Name of matory or other place uneral Home		A/12/2006	Cresapto	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	MARIAN	elli 2	2. Name and Addre Scarpel 108 Viro	ss of Facility Ii Funeral H ginia Avenu	lome, P.A. e: Cumberl	and MD 21	502_
	Physician		23a. Part1. Enter the disease, of complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each ill	I the death. Do not en ne. . in div		ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death
8760, ~	The law requires that the death certificate be executed as the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (usease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):	. 0				0
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rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death bi	ut not resulting in the u	ınderlying cause gıv	en in Part I.			e to the cause of death? Probably 4 □Unknown
Il Records,		Completed						24a. Was ar autops perforn 1 Yes 2	prior death	autopsy findings available to completion of cause of ? 'es 2 \sum No
Vital	5 CB 6	o Be	25. Was case referred to medical examiner?	ospital:		oth Control		ath (Check only one		
of	Te Te	H	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day		of 28c. Injur	y at	lome 5 ☐ Reside 28d. Describe ho	nce 6 Other (S w injury occurred	pecify)
Division		Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Str. City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in	edical	(Check only 2 Medicel Examir	icien: To the best of er: On the basis of and manner sta	of my knowledge, deal examination and/or in ited.	h occurred at the tire	me, date and place pînion, death occu	, and due to the ca rred at the time, da	use(s) and manner ite and place, and c	as stated. fue to the cause(s)
)	To the twithin 2. To the Complet	Σ	29b. Signature and title of certifier	1		29c. Licens	e number 36766		April (L	
	10		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type,	Print)				
	Sta Registr		Vikramaditya Poon 31. Date filed (Month, Day, Year) APR 1 7 20	ai M.D. 32. Abgistra	924 S ar's Signature	eton Drive	e Cumber	land MD 2	21502	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Month Year March 26, ESTHER FRANCES FILIPPI 3:45 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 173-07-0406 Yrs. Director 91 New Jersey 19, 1914 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 le marked other then "neturel; or Items 23e or 28e-f show traumatic event, the Medical Exercit me mail be netified at 1 X Yes 2 □ No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. a filed within 72 hours after death val Hygiene. other then "neturel", or Items 23s 2501 Musgrove Road 20904 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager 12 Elementary School permit. Pagas 1 and 2 should ba file Department of Health and Mental Hy Important: If Itam 27 Is marked oth any injury or other traumatic event 9DRg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 David Drexel Elsie Staiger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Belford Place, Takoma Park, Maryland 20912 Sandra Filippi - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ Removal from State 3/31/2006 Fort Lincoln Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. Jase 4739 Ealtimore Ave., Hyattsville, MD 20781 Conslance 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dysphagia resulting in death) /Medical Due to (or as a consequence of): **Examiner** Malnutrition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Pneumonia been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoporosis 1 Tes 2 No 3 Probably 4 Unknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes To the Hospitel or Attending Physicien: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certification: To 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4₺ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and Itle of certifier 29d. Date signed (Month, Day, Year) 0053235 March 27, 2006 an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Darryl Anthony Hill, MD 13635 Baltimore Avenue, Laurel, Maryland 20707-5095 31. Date filed (Month, Day, Year) MAR 3 1 2006 32. Registrar's Signature State Registrar

			1 - For State Registrer	State of	Maryland /		artment rtificate			and M		giene Reg. No.	15	11980
	Physici /Medic		1. Decedent's Name (First, Midd HAZEL K. FRA								2. Date of Dea		Year	3. Time of Death 19:39 Рм
	Examir		4a. Facility Name (If not institution CHESTERTOWN N			TION			Location o			4c. Coun	ty of Death KENT	.1
	Funeral Director		5. Social Security Number 216-10-2007 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	Age (In yrs. last i	birthday) Yrs.	If Under	1 Year Days	If Under: Hours		8. Date of Birt Month, Pay JUNE ,	1 9 09	Cou	place (State or Foreign ntry) yland
	Maryland -1 show	tor	10a. State 10b. County	y ENT	10c. City, To		cation ERTOWN	[10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	ai Director	10e. Street and Number 415 MORGNEC R	OAD			10f. Zip		520			10g. Citizen of	What Cou	ntry?
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Maryland 21215-0036	filed within 72 h Hygiene. other then "netu ent, ire Medica	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4	or 5+)	(Give life. L	lent's Usual kind of work OO NOT use CUTTE	k done a e retired,	uring most				PROCI	dustry ESSING
yland	should be filed within and Mental Hygiene. s marked othar than umatic avant, Ire M	To Be	17. Father's Name (First, Middle, CHARLES KELLE	Y			•		G1	RACE	(First, Middle, SCOTT			
	1 and 2 sho Health and Iam 27 is m		19a. Informant's Name/Relation: WILLIAM KIRLI		EW	912	STARB	IT F		OWSO	N, MD 2	1286		
Baltimore,	permit. Pages 1 and Department of Heall Important: If itam 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other (5)	Specify)	20b. Place cemer CHESA	PEAK	E CRE	her place MAT I	ON	04/0	8/2006	20c. Location	ISVILI	LE, MD
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8760,	cate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence	, 								
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal deat at time of death		Ectopic pre						ate of delive	ery Day Year
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Division of	Jing After fune	Certification:	Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	not be	Day Year) 28b.	Time of Injury	М		at ? es 2 □ N	lo	8d. Describe ho			l Route Number,
<u>≥</u>	To the Hospitel or Attence within 24 hours after death To the Funeral Director: completely filled in by the	al Certif	4 Homicide determ	ng Physician: To the be	etc. (Specify)				data and		City or Town	n, State)		
	To tha Hoi within 24 h To tha Fur completely	Medical	(Check only 2 Medicel one) 29b. Signature and title of certific	and manner	or examination a	ind/or inv	estigation, i	n my opi	nion, death	occurre	d at the time, d	ato and place,	and due to	the cause(s)
	T W I		29b. Signature and little or certain							86		9d. Date signe		*
	Sta Registra		30. Name and address of person ANDREW S	FERGUS	death (Item 23a) trare, Signature	(Type, F 20	SPH	R.	(D)	BUIL	DING B	CHE	TEXIO	WN MD 21620

Amended Item 3 per Physician 04/03/2006 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Danh 03 **Physician** 2006 6:40 P Donald Patrick Frawley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1∰M 2□F Days Hours Yrs. Director 505-22-2223 01/18/1925 NEUsual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Harford MD Forest Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Lockhart Circle Apt E. 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify. þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 IBM Control Clerk Technology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Frawley Florence Van Cleave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18001 Marshall Mill Rd. Hampstead MD 21074 Barbara Wirts Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition AprilDate 20c. Location - City or Town, State Department of himportant: If Ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Glen Haven Memorial 4 ☐ Donation 5 ☐ Other (Specify) 1, 2006 Glen Burnie MD 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licenses Steven Eline Moo723 934 South Main Street Hampstead MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LCG'OH disease or condition resulting in death) /Medical Examiner 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA 27. Manner of D ath (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 4 Homicide

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To the Hospital within 24 hours a To the Funeral D

Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after death with and Mental Hygiene.
Is marked other than "natural", or iteme 23a or

of Health a

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatus and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) janskaya 500 Upper Chesapoake Dr. Bol

31. Date filed (Month, Day, Year) APR 03

Registrar DHMH 17 Rev 1/2001

State

WJL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death

Division of Vital Records, P.O. Box 68760,

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Registrar

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nent of Health int: if item 27 t iry or other tra		20a. Method of Disposition 1 ፟ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	20b. Place ceme	of Dispos tery, crem	ition (Name of atory or other pla CEMETER	ace)	Date 3/2006	20c. Location - C DEERFIEI	ity or To	
Department of the function of		21. Signature of Funeral Service Licen	un Glor	ke	22.	Name and Addr		BOUNDS	FUNERAL JRY MD 21	HOMI	
ysician		23a. Part . Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	cations that caused one cause on each line		o not ente	r the mode of dy	ing, such as cardia	or respiratory ar	rest,		Approximate Interval Betwee Onset and Dear
Medical caminer		resulting in death)	Due to (or as a	consequenc	ce of):						
and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c. Due to (or as a								
ig physicien and as the burial-transit	edical E		d								
by the attending physicien tached for use as the buria	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 🗌 Fetal dea		Ectopic pregnand Other (specify)	су		23d. Date Month		ery Day Year
signed b	d by Pi	Part II. Other significant conditions co	ontributing to death bu	t not resulting	g in the un	derlying cause g	iven in Part I.		obacco use contrib res 2 \(\text{No} \) 3		ne cause of death
ete hes been si page 2 should b	Completed by								an 24b. We pro	ore auto or to cor ath?	psy findings avai
this certificete hes b	0	25. Was case referred to medical					26 Place of Dec	1 ☐ Yes ath (Check only o		Yes	2 No
2 D	10 B	1 195 200NO	Hospital: 1 Impatien		Outpatient	30 DOX 1	ther: 4 🗆 Nursing H		tence 6 □Other	(Specify	v)
r death. octor: After I by the funera	atlon	27. Manner of Death ↑ Natural 5 Pending 2 Accident investigation		Year) 28b). Time of Injury		ıryat ork?]Yes 2∐No	28d. Describe h	now injury occurred		
el Direct ed in by t	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, . (Specify)	farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number vn, State)	or Rura	I Route Number,
within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a Certifier 1 erti ying Ph (Check only one) 2 Medical Exam	sician: To the best of iner: On the basis of and manner stat	examination:	tga, death and/or inv	estigation, in my	ime, date and plane opinion, death occu	and due to the corred at the time, o	nause(s) and mann date and place, an	er as st of eub b	uted. the cause(s)
To t	Σ	29b. Signature and title of certifier Dan M.D.				05	se number 7952		29d. Date signed (20	06
m		30. Name and address of person who of Bobulat Dan A 31. Date filed (Month, Day, Year) APR 0 3	completed cause of de	eath (Item 23a	a) (Type, F	orint) ST. #	504B S	aliban	1 MDZ	180	0 #-
Stat	te	31. Date filed (Month, Day, Year)	32. Redistrai	r's Signature		1			,		10

			1 - For State Registrar	State of Maryl		artment rtificate			Mental Hy	ygien Reg. N		And the second s	8 !:
	Physici		1. Decedent's Name (First, Middle, Las Lloyd James	Flynn,	Sr.				2. Date of D Month Apri		^{ay} 2006 ^{Year}	3. Time 9:03	of Death a. M
	/Medi Examir		4a. Facility Name (If not institution, give	ŕ			own, or L	ocation of De			c. County of Death		
	- Funeral Director		5. Social Security Number 6. Security Number 578-42-0182 Usual Residence of Decedent	TXM alle	73 Yrs.	If Under 1		If Under 24 H Hours Mi	n. (Month, D	ay, Yeai		place (State	or Foreign
	e Maryland 8a-1 show	ctor	10a. State 10b. County Maryland Montgon		City, Town or Lo Wheaton		-					10d. Inside I	City Limits
	h with th	ai Dire	10e. Street and Number 12702 Feldon Stre	et		10f. Zip (10g. C	itizen of What Cou USA	intry?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If Item 27 is marked other then "natural; or Itema 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? **EYes 2 □ No If Yes, Give Year or Dates: Ju		If Yes, specif	fy Cuban,	panic Origin? Mexican, Pui Specify:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Amer Black, White SpecifyWhit	, etc.	
21215-0036	within 72 h ene. then "natu he Medicel	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)		(Give	dent's Usual kind of work DO NOT use Chasin	done dui retired)	ring most of w	vorking		Kind of Business/Ir Publishin		nany
Maryland 2	uld be filed Mental Hygi irked other itic event, I	To Be Co	17. Father's Name (First, Middle, Last) Lester Dwight Fl	ynn		0114011	3 3	8. Mother's N	ame (First, Middle Catheri	e, Maide	n Sumame)	g com	<u> </u>
	s 1 and 2 sho of Health and I item 27 is ma other traume		19a. Informant's Name/Relationship (7 Mary N. Flynn/ Da 20a. Method of Disposition	ughter 20		Colera	ine	Road,	Baltimor Date	e, M	or Town, State, Zi ID 21229 .ocation - City or T		
Baltimore,	mit. Page partment o cortant: ff		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licenses))	ate of Hea	even Cer	netery	- 4	il 6, 006 s Funera		eaton, Ma	ryland	đ
Ä	Depar impor eny in		23a. Pant. Enlewhe disease, or comp	Social ?	5	00 Uni	vers	ity Bl	vd, W, S	ilve	me Inc. er Spring	, MD 2	
	Physician /Medical Examiner	Examiner	snock, or near tailure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	a. Metastatic Due to (or as a constitution) Due to (or as a constitution)	Lung Co							Interval Be Onset and 1 Year	etween Death
Box 68760,	death certificate be executed e attending physicien and of for use as the bunal-transit	icai	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a constant of the constant of th	gnancy						23d. Date of deliv	erv.	
P.O. B	that the death	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live birth 2□F 4□Pregnant at time o 9□Unknown		Ectopic preg Other (spec		_			Month	Day	Year
Records, I	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cau	ise given	in Part I.			use contribute to t		
al Rec	The ate h	e Completed	25. Was case referred to medical						1 ☐ Yes	ipsy ormed? 2. IX No	death?	mpletion of	available cause of
f Vital	ysician: iis certific director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	it 3 DOA	04		eath Check only		6 ☐ Other (Specif	iv)	
Division of	Attending Physician: r death. ector: After this certific by the funeral director.	ertification:	27. Manner of Death 1 3 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of Injury	280 M	c. Injury at Work?		28d. Describe			,,,	
DİVİ	i Dirigi	0	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	ecity)				City or To	wn, State			n <i>ber</i> ,
	ne Hospital n 24 hours a ne Funeral to oletely filled	Medical	29a. Certifier 1 ☑ Certifying Phy (Check only one)	sician: To the best of my iner: On the basis of exam and manner stated.	nowledge, death ination and/or inv	occurred at restigation, in	the time, n my opini	date and place on, death occ	e, and due to the curred at the time,	cause(s date an	and manner as s d place, and due to	tated. the cause(s)
ļ	To the within 2. To the complet	ž	29b. Signature and title of certifier	1			License ni D2967		1		te signed (Month, 1 3, 2006		
C	1+1		30. Name and address of person who can Ralph V. Boccia,				e, #4	1100, E	Bethesda,	, MD	20817		
ig.	Sta Registra	te ar	31. Date filed (Month PR), Year) 4. 2										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year LEORA JEANETTE GIBSON /Medical MARCH 27, 2006 2:15A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death SAINT THOMAS MORE NURSING AND REHAB HYATTSVILLE PRINCE GEORGES 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2XX Days Hours Min. Director Yrs. 120 26 3690 18. NEW YORK Usual Residence of Decedent with the Maryland Show 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov Tre Madical Examiner must be notified at Director MD YYes 2 □ No PRINCE GEORGES COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4805 MUSKOGEE STREET 20740 UNITED STATES death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes XXNo Specify: Be Completed by Specify: BLACK 3 ☐ Widowed XX Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4+ OFFICE MANAGER . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if Item 27 is marked other t jury or other traumatic event, In CITY OF NEW YORK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 CAROL GIBSON LEORA SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEREMIAH BROWN / SON 4805 MUSKOGEE ST. COLLEGE PARK, MD 20740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN_CREMATORY 3/31/2006 ALEXANDRIA, VA ture of Funeral Service 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIORGAN FAILURE /Medical Due to (or as a consequence of) **Examiner** END STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. attending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2XNo Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DECUBITUS - NON HEALING 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed: 2 🗆 No 1 Yes XXNo 1 🗌 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4XXX lursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes XXNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Injury XXNatural death. investigation 1 Yes 2 No 2 Accident Director: , 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral I XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 27.06 60 au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4922 LASALLE RD. TULI RAMAN, M.D. HYATTSVILLE, MD 20784 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 31, 2006 **Physician** Wayne Lee GEISBERT 1525 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 15844 Fairview Road Washington Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 11, 1964 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 XM 2 □ F 062-56-0132 Director 41 New York Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show The Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15844 Fairview Road 21740 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 maintenance printing permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If Item 27 is marked oth eny lipiry or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carlos Lee Geisbert Norma Lynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Geisbert - wife 11208 Pepperbush Circle, Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Gap Vet. Cem. 4/6/06 Flintstone, Maryland 21. Signature of Foneral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the diseale, or complications that caused the death. Do not after the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Asphyxiation due to inhalation of exhaust fumes /Medical Due to (or as a consequence of): Examiner S—juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of): Box 68760. physicien Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas performed' 1 ☐ Yes 2 No 1 Yes 2□ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ၉ 1 XYes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred inhalation Certification: 28c. Injury at Work? or Attending 1 Natural 5 Pending of exhaust fumes - selfs after death death. 2 Accident investigation Mar.31,2006 1430 1 Yes 2 No Location (Street and Number or Rural Route Num City or Town, State) 15844 Form 6 Could not be determined 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide in 24 hours the Funerel Dire 15844 Fairview Rd home Hagerstown, Maryland 21740 Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Chock willy 2 X medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 ţ, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HHS TE D01062 April 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Edward W. Ditto, III, 19011 Orchard Terr. Rd., Hagerstown, Md. 21742 5H10+1 31. Date filed (Month, Day, Year) APR U 5 32. Registrar's Signature State Registrar Spelle

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Clayton Grier MARCH 2006 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctors Community Hospital Prince George's Lanham, MD 6. Sex 1 XM 2 ☐ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign PA^{ntry)} 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 0572371945 203-34-8924 60 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itama 23a or 28a-f show any printing or other traumatic avent, the Medical Examinar must be northed at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Prince George's Director MD Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9111 Springhill Lane 20770 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clayton Grier Julia Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude G. Dunlop - Sister 8649 Steeple Drive; Philadelphia, PA 19128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2☐Cremation 3ڴRemova⊌rom State 1 🗆 **X**urial 4 Donatio 5 Other (Specify) White Chapel 04/05/06 Forsterville, PA 22. Name and Address of Facility f Funeral Service Licen 5731 Race Street Nix Funeral Home Phila., PA 19139 23a. Part1. Enter the disease, or complications that shock, or hear failure. List only one cause on he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit the attending physicien Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I detached signed b Part II. Othersignificant conditions continuing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2**)**(No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attanding Physicien: 24 hours after death. Funeral Diractor: After this certifici funeral director, 25. Was case referred to medical 26. Place of Death (Check only on examiner? Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death contined at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29b. Signature and title of certifier 29d. Day signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (T 575 MAIN STREET 31. Date filed (Month, Day, Year) 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Month Clement 12:27 a M April 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Dec. 23, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 € M 2 □ F 219-14-5723 83 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location other then "natural", or Iteme 23a or 28a-f show rent, the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 X X Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 9324 Caroline Avenue USA filed within 72 hours after death thygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1∑Yes 2 □ No
If Yes, Give 1943-46
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: White 3™ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Builder 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Hy
Important: If Item 27 Is marked oth
any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl Edward Gray Bertha May Lowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth C. Swauger, Sr./Nephew 18306 Powhatan Court, Gaithersburg, MD 20877 April 5, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State National Memorial Park Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Jos TRILium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Duesto (or as a consequence of Records, P.O. Box 68760 ician/Medicat IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Detai death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f Physi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown -iballATion page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? ALTERY dISEASE 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Division of Vital To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No ဥ 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 61623 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL AVE Istema Tank 0. 7610 1978 31. Date filed (Modern Day 32. Registrar's Signature

State

Registrar

waste)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) (1)

			1 - For Stata Registrar	State of Maryla	•		te of D		Mental Hy	/gien Reg. N	LUUU	11989
	Physici /Medic		Decedent's Name (First, Middle, Last)	Sidney		GEF	STENF	ELD	2. Date of De Month March	D	ay Year	3. Time of Death
+	Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. Cit	, Town, or L	ocation of Dea			c. County of Deal	h
	Funeral Director		370 10 3337		rs. last birthday) Yrs.	If Und Months	er 1 Year	Spring If Under 24 Hrs Hours Min	8. Date of Bi	rth a <i>y</i> , Yea	Montgome 9. Bird Co	hplace (State or Foreign untry)
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo					,		
	eho eho	5										10d. Inside City Limits 1 ☐ Yes 2 📆 No
	the N	ect	Maryland Montgome 10e. Street and Number	Ly	Silve					40- 6		
	23a or	Funeral Director	10600 Glenhaven Dr	ive		1	ip Code .0902			_	citizen of What Co ted Stat	*
920	should be filed within 72 hours atter death with the Maryland of Mental Hyglene. marked other then "neture!, or iteme 23a or 28e-f ehow imatic event, if a Medical Examinar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW		Was Dec If Yes, sp 1 ☐ Yes		panic Origin? (S , Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	0-	14. Race - Ame Black, White Specify: wh	e, etc.
ည	72 hc	ted	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Us	ual Occupati	ion iring most of wo	oduna	16b.	Kind of Business/	industry
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Maryland 21215-0036	lould be filed wi I Mental Hygien Parked other th	To Be (17. Father's Name (First, Middle, Last) Sam Gerstenf	eld ·			1		me (First, Middle Kramer	, Maide	n Surname)	
a	2 should and Men ie marke sumatic		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Addre	ss (Street an	nd Number or R	ural Route Numb	er, City	or Town, State, 2	Zip Code)
	1 end 2 Health tem 27 i		Eleonore Gerstenfe						, Silver	Sp	ring, MD	20902
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	onioval from State	Place of Dispo cemetery, creating Davi				04/06		Location - City or 1s Chure	
Balti	permit. Pages Depertment of Important: if i any injury or one		21. Sign ture of For eral S rvice License	8	To	Name a	nd Address	of Facility Hebrew	Funeral	Hom	e	,
			23a. Part1. Enter the disease, or complic	cations that caused the de	eath. Do not ent	4 Ca	rroll	St. N	W, Washi	ngt	on, DC	20012 Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		0. 0.0	do or dying,	30011 00 001010	o or respiratory b			Interval Between Onset and Death
and a	Physician /Medical		disease or condition resulting in death)	Emphysema								
п	Examiner			Due to (or as a cons								
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	nsit	딡	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(3. 2. 2								
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9	ifficat g phy as th	edical								-		
X R R	eath certific attending p	M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pre	gnancy	ne					23d. Date of deli	very
	a death he atte ed tor	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F 4 Pregnant at time of 9 Unknown		Dectopic Other (s	pregnancy specify)				Month	Day Year
7. O	at the de	P.	9 Unknown						T			
Hecords,	w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	ed by	Part II. Other significant conditions cont History of Malign		resulting in the u	nderlying	cause given	in Part I.				the cause of death?
ပ္က	N S S	plet							24a. Was	an	24b. Were au	topsy findings available
Ĭ	sicien: The la s certificete ha lirector, page 2	Completed								ormed?	prior to death?	completion of cause of
Vital	en: rifice tor, p	a	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath Check only		0 10165	2 NO
	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 17 Inpatient 2	☐ ER/Outpatien	t 3 🗆 C	Other				6 ☐Other (Spec	cifv)
	ig Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year,	28b. Time of Injury		28c. Injury a Work?		28d. Describe			
ğ	Attending Indeath. ector: After by the tuner	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(monor, buy 1 out)	, injury	м		s 2 No				
DIVISION	spital or Atte ours after de nerei Directo filled in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str cify)	eet, facto	ry, office		28f. Location (City or To	Street a	and Number or Ru te)	ral Route Number,
	9 4 7 9 9 P	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my ker: On the basis of exam and manner stated.	nowledge, death	occurre vestigatio	d at the time, n, in my opin	, date and place nion, death occu	e, and due to the urred at the time,	cause(: date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			25	c. License r	number		29d. D	ate signed (Monti	. Day, Year)
)	->-0		1 (3)	EZ			D 00	063136			ril 2, 2	
	19.		30. Name and address of person who con	npleted cause of death (I	tem 23a) (Tyne	Print)						20910
	911		Richard Thomas Mah			,	ant Av	ve. B1	dg. 511A	, S	ilver Sp	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	and.			-	-	•	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Physician Month William John Garvey March 31, 4:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6001 Ammendale Road Prince George's Beltsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, YOCt. 29, 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 216-24-8802 76 Yrs 1929 Director Pennsylvania Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show rsi', or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Maryland Prince George's Beltsville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6001 Ammendale Road 20705 IISA death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after I ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2X No Specify: ģ 3 Widowed 4 Divorced "naturs!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Religious Education svant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame and Mental I John B. Garvey Caroline Marie Campbell ၉ traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James P. McErlean, F.S.C. Religious Supervisor Health a permit. Pages 1 and Department of Health Important: If itsm 27 any injury or other tr. 90ce. 6001 Ammendale Road, Beltsville, MD 20705 Date 4 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 1 XBurial 2 Cremation 3 Removal from State La Salle 4 ☐ Donation 5 ☐ Other (Specify) 2006 Beltsville, Maryland (Christian Brothers) Cometery 21. Signature of Filheral Service Lichsee Francisd Addes Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Me 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pancreatic Cancer Approx. 2 **YMedical** Due to (or as a consequence of): Months Examiner Liver Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examin The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Dunknown مَ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown should ! 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate 1 Tyes 1 Yes 2 No Division of Vital 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sta Residence 6 Other (Specify) ٩ 1 Yes & No 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending Injury 1 Tyes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 045014 MARCH 31 30 Name and address of person who completed cause of death (Item 23a) (Type Print) Isabella Martire, M.D. 8343 Cherry Lane, Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 0 4 2006 BALL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year ESTHER MARION HOWELL 2006 March 8:15 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3111 Nicholson Street Hyattsville Prince George's 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex Days Hours 1 □ M 2 🗓 F 85 1921 220-10-4872 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 3111 Nicholson Street U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Buyer Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harmon Porter Elsie Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4206 Wicomico Avenue, Beltsville, Maryland 20705 Nial L. Howell - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/30/2006 Alexandria, Virginia 21. Signatur of Funeral Service Vicensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 uchell 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myeloid Leukemia Month Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Proysician /Medical Examiner

Physician

/Medical

Examiner

Director

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7 is markad other than "neturel", or items 23e or 28a-f ahow treumetic event, the Madical Examiner must be notified all

a filed within 72 hours after dan Hygiene. Other then "neturel", or item

permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Importent: If item 27 is marked oth any injury or other treumetic event

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

with the Maryland

Examiner certificate be executed anding physician and usa as the burial-transit Physiclan/Medical requires that the death the a þ þ Completed certificate To the Hospital or Attending Physician: Be Lo this funeral Certification: After death. Director: after within 24 hours a

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🗙 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 💥 No 1 Inpatient 2 ER/Outpatient -3□ DOA 4 Nursing Home 5 N Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certifier 29c. License number maicia

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO D 85176

29d. Date signed (Month, Day, Year)

2 No

Marcia Lee Will, MD 7525 Greenway Center Drive, Suite 205, Greenbelt, MD 20770

31. Date filed (Month, Day, Year) MAR 3 1 2006

			1 - For State Registrar	State of Maryla		artment of H			iene 006	11992
	Physici		Decedent's Name (First, Middle, L. Robert Edward I					2. Date of Death	Day Year	
1	/Medic Examin		4a. Facility Name (If not institution, gi		>	4b. City, Town, o	r Location of Dea	April	4c. County of De	
	Funeral		5. Social Security Number 6.	10 V M 2□ E		If Under 1 Year Months Days	erstown If Under 24 Hr Hours Mir	S. 8. Date of Birth	Washing	rthplace (State or Foreign
	Director		Usual Residence of Decedent	/				Jan 26,		nnsylvania
	Marylar f ehow	tor	10a. State 10b. County Maryland Washin		ity, Town or Lo Hage	erstown				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28a	Director	10e. Street and Number			10f. Zip Code	·	10	og. Citizen of What C	Country?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23e or 28e-f ehow eny injury or other traumatic event, the Medical Examinat must be notified at ODGs.	by Funeral	13023 Blue Ridg	e Road 12. Was Decedent Ever in the Armed Forces?	J.S. 13.		21742 lispanic Origin? (Specify Yes or No- rto Rican, etc.)	U.S.A	encan Indian,
036	al', or its		1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 NYes 2 No 2-	6 56	1 ☐ Yes 2 X No		no mean, ac.,	Black, Wh	White
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Man	id 2 sho lth and I 27 is me traume		19a. Informant's Name/Relationship		1		and Number or F	lural Route Number,	City or Town, State,	Zip Code)
Baltimore,	ges 1 ar t of Hea if Itsm 2 or other		Cheryl Lynn Hen 20a. Method of Disposition 1 Burial 2 □ Cremation 3	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other place	:0)	Date 2	own Maryl Oc. Location - City o	r Town, State
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Ö	P P P P		Dunglo d	V Jury	11	331 Faste	rn Blyd	N. Hager	stown Mar	yland 21742
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<u>0</u>	ding f	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	/at ⟨? Yes 2∐No	28d. Describe how	w injury occurred	
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	6 수 교 수	edicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my or	ne, date and place pinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner a te and place, and du	s stated. e to the cause(s)
1	To the within 2. To the I complet	Me	29b. Signature and title of certifier	2 a real Hose	DITALL	29c. License			d. Date signed (Mon	
,			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	0653	.46	04 0° erstow	3 06.
5H	5+1		Dr. Mercy K 31. Date filed (Month, Day, Year)	urapaty 32. Begistrar's Signa		: Antie	tan S	st. Harq	erstow	n MD
	Sta Registra		APR 0 5 2	006 1	M. Ans	chi				

			1 - For State Registra AMEND#3perMD4/			artment of H rtificate of			Reg. No	UUU.	measured .	93	
	Physici /Medio		Decedent's Name (First, Middle, Last John Heard					2. Date of De Month March	Da	y Year 2006	3. Time o	PM _M	
	Examir Funeral		4a. Facility Name (If not institution, given 104 East Melrose 5. Social Security Number 6. S	ST	last birthday)	4b. City, Town, o Chevy If Under 1 Year	Chase	irs. 8 Date of Bi	nth M	County of Dealontgome		or Foreign	
ı	Director		Usual Residence of Decedent	₩ 2□F 94	Yrs.	Months Days	Hours M	Sept.	8, Year)	911 Mas	s.		
	the Maryla 28a-f ehov	Director	10a. State 10b. County Maryland Montgome 10e. Street and Number		vy Cha	se	**		10- 0			ity Limits	
	3a or	Ē	104 East Melrose	ST.		10f. Zip Code 20815				tizen of What Co	ountry ?		
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other then *naturel', or iteme 23a or 28a-1 ehow empty injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 25 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		14. Race - Ame Black, White Specify:			
215-0	thin 72 ho e. en *natur Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of a	working		ind of Business Lce Of T	Industry	retar	
Baltimore, Maryland 21215-0036	be filed wi	Be Con	17. Father's Name (First, Middle, Last)	5	Engir	neer	18. Mother's N	Name (First, Middle	'	Defense	<u>.</u>		
yla	J Men	2	John Heard	F O	1 .0			Clifford					
a Z	id 2 st ith and 27 is n traun		19a. Informant's Name/Relationship (Helen Heard /	Wife		ng Address <i>(Str</i> ee <i>t</i> East Melr			-	or Town, State, . e, Md 20			
ē,	S 1 and Items of the man		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other place	- I	Date		ocation - City or			
altimo	mit. Pege partment o portent: If injury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funderal Service Licer	Nat	ional	Cremator Name and Addre	y Apr	il 3,06 Joseph Ga		lls Chur		•	
ä	F G E G		William R.	Deyer		30 Wiscon		-			-	6	
1	Physician		23a. Part 1. Enter the dis 1 se, or com shock, or heart fail 1 e. List only Immediate Cause (Final disease or condition	plications that caused the deat one cause in each line. Pneumo	h. Donoten						Approxima Interval Be Onset and	te tween Death	
H	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):				3 Weeks				
8760,	icate be executed physicien end s the burial-transit	dlcal	resulting in death) Last	C. Due to (or as a conseq d.	uence of);								
P.O. Box 6	The law requires that the death certificate be executed to hes been signed by the ettending physicien end age 2 should be deteched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3[Ectopic pregnancy Other (specify)	,		23d. Date of delivery Month Day Ye			Year	
	w requires thet been signed t should be det	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		tobacco i	use contribute to	the cause of obably 4		
Division of Vital Records,		Completed						24a. Was auto perfo 1 Yes	psy ormed?	prior to death?	topsy findings completion of c	available cause of	
Z	nysicien: Th nis certificete i director, pag	Be	25. Was case referred to medical examiner?	Hamitali.		104		eath (Check only	опе				
0	Phys this ral dii	7	1 ☐ Yes 2 Ñ No 27. Manner of Death	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input	ER/Outpatier 28b. Time o		4 Nursing	Home 5 Resi			cify)		
Sion	5 a 5	Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	Injury	M 1	k?` Yes 2 □No						
2	itel or A irs efter rai Direc led in by		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y) 			City or To	wn, State			iber,	
	To the Hospitel or Attendit within 24 hours efter death. To the Funeral Director: At completely filled in by the fu	edical	29a. Certifier (Check only one) Contifier Continue	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the courred at the time,	cause(s) date and) and manner as d place, and due	stated. to the cause(s	s)	
		W	29b. Signature and title of certifier.		W	29c. Licens				te signed (Mont.			
	12		30. and dd/ss o person who	completed cause of death (Item	1 23a) (Type,	1				519 2			
	7252		JOhn M. Wiseman			Ave, N.	W. Wash	ington D.	C. 2	20015			
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	Ture	refer of							

			1 - For State Registrar	State of Ma	arylan		artmen <i>rtificat</i>			nd Me		giene leg. No.	6	11994	
	Physici	an	Decedent's Name (First, Middle, Last								2. Date of Dea Month	ith Day	Year	3. Time of Death	
	/Medi		Marvin	C.		F	lardir				March	7	2006	11:05 PM	
	Examir	ner	4a. Facility Name (If not institution, give 2305 Shorefield				1		Location of Sprin			4c. County of Death			
- 12°		ঙ	5. Social Security Number 6. Se		a (In vre	last birthday)	If Under		If Under 24	_	R Date of Birth		ntgor		
3	 Funeral Director 		579-01-0223	2 M 2 □ F	94		Months	Days		Min.	March	7, Year) 7, 1912	Was	place (State or Foreign htry) nington, D(
-			Usual Residence of Decedent									,, 1312			
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits	
	a-f-	cto	Maryland Montgome	ery	Si	lver S	Spring	3						1 Yes 20 No	
	or 28	Dire	10e. Street and Number				10f. Zip				1	10g. Citizen of	What Coul	ntry?	
	ath w	rai	2305 Shorefield Ro					902				US			
	within 72 hours after death with the Maryland ane. then "natural", or items 23a or 28a-f ehow a Madical Examinat must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13.	Was Deced	lent of Hi ofy Cuba	spanic Origir n, Mexican, i	n? (Spec Puerto R	rfy Yes or No- ican, etc.)	14. Ra Bla	ce - Americk, White,		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 🔯 ! If Yes, Give Year or Dates:	NO		1 🗆 Yes	2 K No	Specify:			Specia	White		
21215-0036	tura el E		15. Decedent's Edu			16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of E	lusinass/In	dustry	
75	9 2	Completed	(Specify only highest grad			(Give	kind of wo	rk done d se retired	luring most o	of working	9	100. 11110 01 2	20111002111	oddify	
2	d within giene. rr then "	E	Elementary/Secondary (0-12)	College (1-40) S)+)	Sa1	.esman	1				Autom	obile		
Q	be filed vital Hygie of other in	0	17. Father's Name (First, Middle, Last)						18. Mother's	s Name	First, Middle,	Maiden Sumai	пө)		
<u>a</u>	2 should be I and Mental I fs marked o	To B	George Harding						Be:	rtha	Housen	nan			
Maryland			19a. Informant's Name/Relationship (T) Carol J. Turner/									r, City or Town		Code) ad 20832	
e,	1 and Health em 27		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nan	ne of		DII		20c. Location			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury o <u>c</u> other treumatic and <u>once</u> .		1 ☐ Burial 2X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		C	emetery, crea ropolita	matory or o	ther plac	9) Ma	arch 200	31,				
Ħ			21. Signature of Funeral Service Licens		1200			_				Alexandria, Virginia ral Home Inc. Silver Spring, MD 2090			
ä	ped dim o		Acomos a	Donda		5	ÖÖ Un	iver	sity 1	Blvd	, W, Si	lver S	pring	, MD 20901	
er.			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that cause ne cause on each lin	the death	h. Do not en	er the mod	e of dying	g, such as ca	rdiac or	respiratory arr	est,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a Atrial F			n								
	Examiner			Due to (or as Coronary			iseas	е							
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o	e exe ian a urial-1		resulting in death) Last	a consequ	uence of);										
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9 ×	death certifica e attending ph id for use as th	/Med	IF FEMALE:	23c. If yes, outcome	of pregna	nev									
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	res that igned b be deta	by Pi	Part II. Other significant conditions co	ntnbuting to death b	ut not resu	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tol	bacco use con	tribute to th	ne cause of death?	
Vital Records,	- w -									_	1 🗆 Y	es 2□No	3 Prob	ably 4 🔁 Unknown	
ပ္ ပ	aw requisible been 2 shout	Completed									24a. Was a			psy findings available	
ř	The te h	E									autops perform	ned?	death?	mpletion of cause of	
Ita	sician: certifica rector, p	Bec	25. Was case referred to medical examiner?						26. Place of	Death (Check only on				
ot <	d is	To	1 Yes 2 XNo	Hospit al : 1 ☐ Inpatie	nt 2 🗌	ER/Outpatier	nt 3 DO	A Othe	r: 4 🗆 Nursi	ing Home	9 5 🔀 Reside	ence 6 Oth	ner (Specify	v)	
			27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injui (Month, Day	y Year)	28b. Time o Injury	2	Bc. Injury Work	at ?	28	d. Describe ho	w injury occur	red		
<u>s</u>	Attending r death. Sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				М		′es 2 □No						
á		Certification:	4 Homicide determined	28e. Place of Inju building, etc	ury - At ho c. <i>(Specif</i>)	ome, farm, str /)	eet, factory	, office		28	f. Location (St City or Town		oer or Rura	l Route Number,	
	Hospita 4 hours Tuneral ely fillec	edical C	(Check only 2 Medical Exami	sician: To the best oner: On the basis of	examina	wledge, deat	n occurred a	at the tim	e, date and p	place, an	d due to the ca	ause(s) and mate and place.	anner as si	ated.	
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and manner sta	ited.			License				9d. Date signe			
			10016	X			250		8962					, 2006	
	10	i	30. Name and address of person who co	omoleted cause of the	eath (Item	23a) (Type	Print)								
_			Shashank Patel, M	.D. 2309	Shore	efield		, Wh	eaton,	MD	20902				
25.50	Sta Registr		31. Date filed (Month, Day, Year) APR 0 3 200	32 Registra	ar's Signa	ture	SE)								

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #20a per/fh 04-03-2006 Certificate of Death CNM Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2 Day **Physician** April HENRY FOSTER HUNTER 2008 3:20 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Beverly Healthcare Center Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min. May 2, 1909 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1₩ M 2□F Director 578-40-5327 96 Cuba Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Exercit entrast be notified at Director 1 Tyes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 30 North Place Items 23a 21701 U.S.A. Funera 12. Was Decedent Ever in U.S. Anned Forces? 1 Å Yes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural, or iten
I yo other traumatic event, it is the lical Execular. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Veterans Administration US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Herbert Hunter Florence Henry ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainone. Ronald Hunter / Nephew 13324 Old Annapolis Road, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State Smithsburg Crematory 4/4/06 ¹ 4 □ Donation 5 □ Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service License ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KHEUMONIA Enysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner IENAL AILURE Sequentially list conditions, if any, leading to immediate eause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ξ 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records. ALLURE てっ THRIVE Be Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 certificate 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2. No Hospital: Other: Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mannes of Death 28c. Injury at Work? After ' 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047951 -3-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 814 Toll LOERIC A-KAZMI, Mb HOUSE AUE. SIBTE 31. Date filed (Month Day, 32. Sgistrar's Signature State 2006 en & specie Registrar

			1 - For State Registrar	State of	Maryland / Depa Ce	artment of H			iene	6 1	1996				
1	# 3×	100	Decedent's Name (First, Middle,	Last)				2. Date of Deat	h		3. Time of Death				
	Physici /Medi		Richard	Hooper				March	Day 3.1	Year 2006	8:15 A ^M				
	Examir		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, Town, or	Location of Death		4c. Count	y of Death	0.13 A				
			Charlotte Hall	Veterans H	lome	Charlotte			St. M	lary's					
	Funeral		,	6. Sex 7. 11☑M 2□F	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl Coun	lace (State or Foreign try)				
	Director		215-12-4338 Usual Residence of Decedent		82 Yrs.			May 18,	1923	Mary	land				
	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show deal Exacultar trust be redited at		10a. State 10b. County		10c. City, Town or Lo	ocation				10	0d. Inside City Limits				
	Mar a-f st	tor	MD St. M	arv's	Charlotte	На11					1 ☐ Yes 2 ☑ No				
	th the	Director	10e. Street and Number		Johariotte	101. Zip Code		10	0g. Citizen of	What Coun	try?				
	ours after death with the Marylan ral', or Items 23a or 28a-f show Exa older most be notified at	a	29449 Charlotte	Hall Road		20622	2		U. S	. A.					
	n 72 hours after dea "nature!; or Items	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Ra	ce - America					
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00	hour:	d b	3 ₩ Widowed 4 Divorced		s:& Korea					Wh:	ite				
21215-0036	in 72	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	luring most of work	ing	16b. Kind of E	lusiness/Ind	lustry				
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	illed I Hygid other	Bec	17. Father's Name (First, Middle, L.	ast)	Date	Small	18. Mother's Nam	e (First, Middle, N	Insur Maiden Sumai						
/ar	Aental Aental rked c	To B	Harry R. Hooper Lillian Sadie Hawkins												
Maryland	ges 1 and 2 should be filed within 72 hc it of Health and Mental Hygiene. If Item 27 is marked other then "nature or other traumatic event, the Mudical	-	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailir	ng Address (Street a					Code)				
	and 2 ealth n 27 i		Richard Michael	Hooper /	Son 16415	River Ai	rport Rd	. Brandy	wine. I	MD 206	513				
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Romoval from Str	20b. Place of Dispo	sition (Name of natory or other place	0.5 1.5	Date	20c. Location						
Ē	permit. Pages 1 and 2: Department of Health ar Important: If Item 27 is any Injury or other trau		4 Donation 5 Other (Spe			1d-Echo1s			Charlo	tte Ha	11. MD				
Baltimore,			21. Signeture of Funeral Service Licensee 22. Name and Address of FacilityBrinsfield-Echols Funl. Hme												
	40540		your 1 10	X1 900	M00641 3	0195 Thre	e Notch 1	Rd. Charl	lotte 1	Ha11,	MD 20622				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
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4	/Medical Examiner		resulting in death)		as a consequence of):										
	<u> </u>	er	Sequentially list conditions, if any, leading to immediate	D	o SCIERD HO	<u>Carclu</u>	DVQ (UI)	ar disp	ase						
	uted Insit	i i	cause. Enter Underlying Cause (Disease or injury	540 10 (61	20 2 001/30400100 01/.										
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8760,	cete be executed physicien end the burial-transit	dicai		d											
9	tificel ng phy as th	ledi													
Вох	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		Ectopic pregnancy			23d. Da	te of deliver	у				
	ed fo	sicia	in the past 12 months?		tat time of death 5	Other (specify)			Mo	onth [Day Year				
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0.0	w require been si should t	Completed	COVIGESTI VE	TIEWIT	- ta, w	٠, و		1 Yes	s 2□No	3 🔼 Proba	ibly 4 □Unknown				
Sec	e law	прie	Coronary	Artes	ry clise	ase		24a. Was an autopsy		Were autop	sy findings available pletion of cause of				
Vital Records,		ဝိ						perform 1 ☐ Yes 2		death? 1 ☐ Yes 2	2□ No				
Vit	Physician: T this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Death								
ō	Phys r this ral dii	2	1 Yes 2 No 27. Manner of Death	1 L tnpa			4 DU Nursing Ho	me 5 Resider)				
O	ding I th. After funer	ş	1 Natural 5 ☐ Pending 2 Accident investiga	28a. Date of I (Month,	Day Year) fnjury	28c. Injury Work	es 2 □No	ZOG. Describe nov	w injury occur	100					
Division	Attendia r death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of	Injury - At home, farm, stre			28f. Location (Stre	eet and Numb	er or Rural	Route Number				
Ö	el or	ert	4 Homicide determin	building,	etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)						
	To the Hospitel or Attentwithin 24 hours efter death To the Funerel Director: completely filled in by the		29a. Certifier 1X Certifying	Physicien: To the be	st of my knowledge, death	occurred at the time	a, date and place.	and due to the cat	use(s) and ma	anner as sta	ted				
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Dead in pure stigation 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Nur City or Town, State) 29a. Certifier Creak willy one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and-title of certifier 29c. License number 29d. Date signature and-title of certifier 29d. Date signature and-											the cause(s)				
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	0		29c. License			29d. Date signed (Month, Day, Year)						
			regar	· c V	- ana.	D:	5065	3	3-3	31 - 3	2006				
0	2161		30. Name and address of person wh		1	9/1	AN -C	SUX	21700 19)					
1	ווט			Deale	church to	n Roo	d D	eale	mil	>. 2	0751				
7	Sta Registra		31. Date filed (Month, Day, Year)	2006	strar's Signature	rock o									
19 20			71110	2000	was so the	ALCO - LAND									

			1 - For State Registrar	State of M	aryland				ealth a Death	and M	lental		$\angle UU$	6	11997
	Physici		1. Decedent's Name (First, Middle, Last) Eugene William	Houser							2. Date of Month	of Death th Day 2006			3. Time of Death 12:30 A M
	/Medio Examin		4a. Fecility Name (If not institution, give s Memorial Hospit					Town, or mber	Location o	of Death	-		4c. County	of Death	7
	Funeral Director		255-50-5275	7. Ag	69 (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month	Day, Y	(ear) 1936	Cour	ntry)
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County WV. Mineral			Town or Lo								1	0d, Inside City Limits 1 ☐ Yes 2020No
	h with the 23a or 28a	Funeral Director	10e. Street and Number RR 6, Box 6184				10f. Zip	Code 2672	26			Ac. County of Death Allegany e of Birth Day, Year) 10g. Citizen of What Country) West Virginia 10g. Citizen of What Country? United States Is or No- Black, White, etc. Specify: White 16b. Kind of Business/Industry Paper Manufacturer Middle, Maiden Sumame) Burke Normber, City or Town, State, Zip Code) est Virginia 26726 20c. Location - City or Town, State Cumberland Maryland Funeral Home Country) 12:30 A M			
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If itsm 27 is marked other then "naturel", or itsms 23e or 28e-f show ship injury or other traumatic avent, its Madical Examinar must be nutified at ODGe.	by Funer	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No	l I	Vas Deced Yes, spec	cify Cuba	spanic Ori n, Mexican Specify:	gin? (Sp n, Puerto	ecify Yes o Rican, etc	r No- .)	Bla	ck, White,	etc.
21215-0036	d within 72 ho giene. ir then "natu	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			life. L		rk done d se retired	turina mosi	t of work	ing				
Maryland	uld be file Mental Hy irked other itic svent,	To Be C	17. Father's Name (First, Middle, Last) Bernard Hou	ıser						r's Name Haze			uiden Suman	ne)	
	and 2 sho laith and I n 27 is me sr trsume		19a. Informant's Name/Relationship (Type Mary Ann Houser/ w				_						-		
altimore,	Pages 1: nent of He ant: If itsn ury or oth											mberland Maryland			
Balt	permit. Departr Importa sny inje		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562											1 21562	
	Physicien and physicien and physicien and physicien and physicien and strength and physicien and phy	Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseque	Stroke nce of):	er the mod	le of dying	g, such as	cardiac	or respirato	ory arrest	t,		Interval Between Onset and Death
.O. Box 68760,	The law requires that the death certificate be ale has been signed by the ettending physicionage? Should be detached for use as the bund	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant al	2 ☐ Fetal d	eath 3 🗆	Ectopic pr Other (sp					_	1		
cords, P.	w requires that been signed t should be det	þ	Part II. Other significant conditions con Hypedensico, Diabetes	tributing to death b	ut not result	ing in the un	derlying c	ause give	en in Part I.			Yes	2 🗆 No	3 Prob	ably 4 Unknown
al Rec	n: The lav icete has r. page 2 :	Completed									1 U Y	utopsy erforme es 2	d2	prior to cor death?	mpletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director. page	ıtion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 / Inpatie 28a. Date of Inju (Month, Da	ry 2	R/Outpatient 8b. Time of Injury		8c. Injury Work	at 4 □ Nu	rsing Ho	me 5□1	Residenc			y)
Divis	ai or Attai s after dea i Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et		e, farm, stre	eet, factory	/, office						oer or Rura	il Route Number,
	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best ler: On the basis o and manner sta	f examinatio	edge, death n and/or inv	occurred	at the tim , in my op	e, date an	d place, th occurr	and due to ed at the ti	the caus	se(s) and ma	anner as st and due to	tated. o the cause(s)
)	To the within To the comp	W	29b. Signature and title of certifier	ean, M	1.1)-		290	: License	207			290	Date signe	d (Month,	Day, Year)
			30. Name and address of person who could be seen and address of person who could be seen and the seen and the seen address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person and address of person and address of person and address of person address of person and address of person a	mpleted cause of d	900	3a) (Type, I 5ET	Print)	or.	Cum	BEA	PLAN	10.	MO.	213	502
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 28	32. Registr	ar's Signatu	re M	and the	9							

State of Maryland / Department of Health and Mental Hygiene

					Otate of W	aryland	Certifica		Death	-	Reg. No.	16 1	1998		
	Physicia	m	1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	eth	Vear	3. Time of Death		
	/Medic				Earl Gene	Hartmar				Apri	1 05, 2006		8:45 P.M.		
F	Examine	er	4a Fecility Neme (If ne	ot institution, give	e street end number)				4b. City, Town, or Lo		4c. Count	-			
			5. Social Security Num	Sacre	d Heart Hosp	ital	. f :	ler 1 Year	Cumberl						
	Funeral Director			1	ext 7.Ag KOM 2□F	e (In yrs. las	Yrs. Month			8. Date of Bir (Month, Da		9. Birthpla	ce (State or Foreign		
		ŀ	218-40-337 Usuel Residence of Do	ecedent		_63				March 19	9, 1943	IVI	ii y iaiiu		
	how how		10a. State 1	0b. County		10c. City, T	own or Location					100	I. Inside City Limits		
:	88-1-8	cto	Maryland	Alles	gany				Frostburg				1 ☐ Yes 2 No		
:	20	声	10e. Street end Number	er	, ,		10f. 2	ip Code			10g. Citizen of	What Country	/?		
-	23	a a		20607 Lor	d Road S.W.				21532			USA			
_ 1	ours arter death with the Marylen rel', or theme 23s or 28s-1 show Examiner must be notitied at	Funeral Director	11. Marital Stetus 1 ☐ Never Married	200 Married	12. Was Decedent Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Yes} \)		13. Was Dec	edent of I ecify Cub	Hispenic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Ra Bla				
020	1. or	6	3 Widowed 4		If Yes, Give Year or Dates:	NO	1 ☐ Yes	2 No	Specify:		Speci	fy:	White		
ō j	ineo winn /z nouts arar daam with the Marylend ther than "natural", or items 23a or 28a-1 show ont, the Medical Examiner must be notified at	Completed by	,15	5. Decedent's Ed	ucetion	1	6a. Decedent's Us	ual Occu	pation		16b. Kind of E				
21		6 6	Elementary/Seconda	only highest gree ary (0-12)	College (1-4or 5	i+)	life. DO NOT	vork done use retire	during most of work ad)	ng		Day O5, 2006 S:45 P.M. 4c. County of Death Allegany 4c. County of Death Allegany 9. Birthplace (State or Foreign County) Mary land 10d. Inside City Limits 1			
2	tel Hygiene. d other than	် ပ	12		0		Hea	vy Eq	uipment Oper	perator Coal					
oue		Be	17. Father's Neme (Fir	st, Middle, Last)					18. Mother's Name						
ž	ond Mentel or marked o	2	40- I-f		arence Hartma										
Z Z	thend 7 is m traum		19a. Informant's Name	. V. Articologico de la comp											
ē .	Heal Heal other	1	20a. Method of Dispos	oro i Hartma	in-Wife	20b. Place	of Disposition (N	ame of							
Baltimore, Maryland 21215-0020	y or o	П	1 X Burial 2 □ C 4 □ Donation 5 [Pother (Specific	Removal from State	ceme	etery, crematory or		1 F	April 08,			1000		
	ortan injur	1	21. Signature of Funer				Mt. View C		es of Facility	2006					
Ö	Der in ge		Des C.	Mekey	il,				Eichh				P.A.		
			23a. Part . Enter the c	diseese, or comp ailure. List only o	lications that caused ne cause on each lin	the death. De.	Oo not enter the mo	de of dyir	ng, such as cardiac o	r respiratory ar	rest,	i In	terval Between		
	hysician /Medical		Immediate Cause (Fin	al	0	2_				,		0	nset and Death		
	xaminer		disease or condition resulting in death)	ai	a a Cari	e_	myoc	ardi	ial Inj	arctio	n	an Llewellyn if yor Town, State, Zip Code) Maryland, 21532 Location - City or Town, State Moscow Mills, Maryland e Funeral Home P.A. g, MD 21539 Approximate Interval Between Onset and Death / //2 brouge Go use contribute to the cause of death? 2 No 3 Probably 4 Unknown			
		<u>e</u>			0	Due to (or es	a consequence of):	~ ~				* •		
1	ng physician and as the burial-transit	edicai Examiner	Sequentially list condit	ions	b. <u>CON</u>	Oue to (or as	a consequence of	eny	Orsce.			- - (Jeas		
o,	ian ar urial-t	Ĭ	Sequentially list condit if eny, leading to imme ceuse. Enter Underlyin Cause (Disease or injuthat initiated events	ediate ng		(,		, ,							
68760,	hysic the b		that initiated events resulting in death) Last		c	Due to (or as	a consequence of)	:	-			-			
VISION Of VItal Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate he executed	ding p sa as	5		L.	d							1			
Box	been signed by the attandir	Lingsician										İ			
J. 15	y the	38	Part II. Other significer	nt conditions co	ntributing to death bu	t not resulting	g in the underlying	cause giv	en in Part I.						
ר בּ	a date									101	es 2 ∐No	3 LPTobat	oly 4 □ Unknown		
	cate has been signe page 2 should ba o	3								24a. Wes a	in autopsy	24b. Were	autopsy findings		
00 8	s bee 2 sho									perfor	med?	comp	letion of cause		
Y e	te ha	5								1 T	es 2 MNo				
DIVISION OF VITAI RECORDS, or Attending Physician: The law requires to	ertifica ector, p	2	25. Was case referred	to medical					26. Place of Death						
V V	this ce	2	examiner? 1 ☐ Yes 25 No	ŀ	łospitel: 1 ☐ Inpatier	nt 2 ERV	Outpatient 3L/D	OA Oth	er: 4 Nursing Hon	ne 5 Resid	ence 6 □Oth	er (Specify)			
ם פ	ther th	<u> </u>	27. Menner of Deeth	Pending	28e. Date of Injun (Month, Day	Year) 28t	o. Time of Injury	28c. Injur Wor	y at k?	8d. Describe h	ow injury occur	red			
Sign	tor: A	8	2 ☐ Accident 3 ☐ Suicide 6	investigation Could not be	00 Bi (11)		М		Yes 2 □ No						
- 5	# = c		4 Homicide	determined	building, etc.		farm, street, factor	y, office	2	City or Town		er or Rural R	oute Number,		
ioitai	nersi filled	5	29a. Certifier 1	Gertifying Phys	ician: To the best of	my knowled	ge, death occurred	at the tin	ne, date and place a	nd due to the a	ausale) and m	nner ac stat-	d		
e Ho	within 24 hours eftar death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	3	(Check only 2	Medical Exami	ner: On the basis of and manner stat	examination a	and/or investigation	n, in my o	pinion, death occurre	d at the time, d	ate and place,	and due to the	e cause(s)		
Tot	To the	_	29b. Signature and title	of certifier)	29	c. Licens	e number	2	9d. Date signe	d (Month, Day	r, Year)		
				1	cms 1	/		G_{i}	21244		4/6	121	006		
	4	3	30. Name end address	of person who co) (Type, Print)	_			, , ,	, , , ,			
	1	1	JESUS /	4. TAN		OAQU	vay F	2057	thung 1	narylu	wol	215	32		
	State Registrar		31. Date filed (Month, D		32. Registrar	s Signature	a A	8 20							
				200	ALLER	All Sa	P AND THE	The same of the sa							

			1 - For State Registrar	State of	Maryland / De <i>C</i>	partment of e <i>rtificate of</i>		nd Mental Hy	ygiene		11999				
	Physic	ian	1. Decedent's Name (First, Middle, La Agnes Nell		uck		-,	2. Date of D Month	eath	Year	3. Time of Death				
in the	/Medi	cal				1		Marc		20°06	7:35a м				
1	Exami	ner	4a. Facility Name (If not institution, giv Williamsport			4b. City. Town, Willia			4c. County Wash	of Death Lingt	on				
	Funeral		Social Security Number 6. S	Sex 7.	Age (In yrs. last birthda	y) If Under 1 Yea	If Under 24	4 Hrs. 8 Date of Bi	of Birth 9. Birthplace (State of						
	Director	ı	220-28-8937	□ M 2 🟋	77 _{Yrs.}	Months Days	Hours	Min. (Month, D	7,1928	Count	stria				
	end we		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10	Od. Inside City Limits				
	Maryl	tor	MD Washin	gton	Willi	amsport					11√2 Yes 2 □ No				
	th the or 28a e notifi	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of V U.S.	/hat Count	ry?				
	23a c	rai	154 N. Artiza	n St.		217	/95		U.S.	Α					
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f ehow any injury or other traumatic event, the Mudical Example must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? No	B. Was Decedent of if Yes, specify Cult 1 ☐ Yes 2 ☐ X to		n? (Specify Yes or N Puerto Rican, etc.)		e-Amenca k, White, e Whit	itc.				
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a. Dec	edent's Usual Occu	pation	of working	16b. Kind of Bu	siness/Ind	ustry				
121	within nne. than	mpi	Elementary/Secondary (0-12)	College (1-4	life life	DO NOT use retire	ed)	a working	resi	dend	ce				
9	Hygie Hygie other	ပိ	12th grade 17. Father's Name (First, Middle, Last)	U				s Name (First, Middle	Maiden Sumam	a)					
<u>lan</u>	Aental Aental rked c	To Be	Balthasar Wi	eland			Mar	ia Hansm	ann	5)					
Maryland	ind 2 sho alth and N 27 ts ma		19a. Informant's Name/Relationship (Peggy Faith d	ner. City or Town. State Zip Code:											
altimore,	Pages 1 annent of Heant: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control of the contr		20b. Place of Dis cemetery, ci Little	position (Name of ematory or other plants Rose H.	L11 A	pril 3, 2006	20c. Location - Clear	City or Tov	vn, State Lng, MD				
Balt	permit. Departr importe any inje		2) Signature of uneral Society en	*		22. Name and Addr Donald I P.O.BOX	ess of Facility Edwin 310 C	Thompson lear Spr	Funera	1 Ho	ome,Inc 722				
Н			P.O.BOX 310 Clear Spring, MD 21722 23a Power first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation Course (Circle)												
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Poe	umonia						Onset and Death				
	Examiner			-	as a consequence of):		. 6	C							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Bue to (er	CLSSIVE NA as a consequence of):	wrologi	caeci	ine tolle	wing STV	OKS	years				
	acutad ind transii	Examiner	Cause (Disease or injury that initiated events	c					9						
60,	cate be executad physicien end the burial-transit	EX	resulting in death) Last	Due to (or	as a consequence of):										
58760,		dicai	•	d											
. Box	at the death cartifi by the ttending packed or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnanc □ Other (specify) _									
	taw requires that the as bean signed by the should be detache	by P	Part II. Other significant conditions co	ontributing to death	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use contri	oute to the	cause of death?				
Hecords,	w require bean sig should b	edb	Rheumatoid	Arthr	itis			1	Yes 20046	B ☐ Probal	oly 4 Unknown				
မိုင်	as be	Completed						24a. Was	an 24b. W	ere autops	sy findings available pletion of cause of				
-	: The tav	Con						autor perfo	imed:	ath?					
VITA	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	-			Death Check only o	one						
ō	Phys	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpa 28a. Date of In			4 Laprursii	ng Home 5 Resid	dence 6 Other						
<u>o</u>	r Attending F er death. rector: After by the funer	ation	1 Delatural 5 Pending 2 Accident investigation	(Month, L	Day Year) Injury	Wo	k? Yes 2 ∐ No		now injury occurre	a					
DIVISION	or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I	njury - At home, farm, s etc. (Specify)	reet, factory, office		28f. Location (S City or Tox	Street and Number	or Rural I	Route Number,				
_	pitel o		20. Castian de factorio ph												
	To the Hospitel or Attending Physician: within 24 hours elfer death To the Funeral Director: After this certific completely filled in by the funeral director.	ledicai	one)	iner. On the basis and manner	st of my knowledge, dea of examination and/or is stated.	th occurred at the time	ne, date and p pinion, death o	place, and due to the poccurred at the time,	cause(s) and man date and place, ar	d due to the	ed. ne cause(s)				
	유를 다 등	Σ	29b. Signature and title of certifier	ملد د	~ A	29c. Licens	9 number		29d. Date signed						
1	78	-	> Cynthia Ki	mer - 2	ands, ra	V 4				March 31, 2006					
	7		30. Name and address of person who countria Kuttner	sands mi	death (Item 23a) (Type	Print) NAI	sing t	tome	Willia + Mar	mspt	4 21145				
	Stat Registra	te ar	31. Date filed (Month, Day, Year) APR 0 2 20	32. Flogis	strar's Signature	sente)		7.1.2.13		,					

			1 - For State Registrar	State of Ma	aryland /	•	artment of I <i>rtificate of</i>		Mental Hy	giene		12000
			Decedent's Name (First, Middle, La	st)					2. Date of De	eath		3. Time of Death
	Physici		Dennis C. Ho	over					March	Day 2.9	Year 2006	8:21 P M
de la	/Medio Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of Deat			ounty of Death	
	LX	٠,	Shady Grove Adve	ntist Hosp	ital		Roc	kville		Mo	ontgome	* 77
	Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.		rth	9. Birth	place (State or Foreign
	Director		205-42-2247	IXM 2□F	53	Yrs.	Months Days	Hours Min.	Oct.			intry) ` A
	2		Usual Residence of Decedent									
	how how		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	9 Ma	Director	MD Montgo	mery		(Germanto	wn				1 ☐ Yes 2 🛣No
	다 다 188 a 198	lre	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	intry?
	23a	<u> </u>	18818 Liberty M	ill Road				20874		Unit	ted Sta	ites
	ems L	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. \	Was Decedent of it f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	o- 14.	. Race - Ameri Black, White	
õ	or it	F.	1 ☐ Never Married 2 ☐ Married	1 □ Yes 2 🔯 N If Yes, Give	No		1 ☐ Yes 217 No	Specify:		Sı		
5-003	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow ha Medical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			21				WI	nite
Ÿ	72 mat	Completed	15. Decedent's E (Specify only highest gr		10	(Give	tent's Usuat Occup kind of work done DO NOT use retire	during most of wor	rking		of Business/Ir	,
2121	withly ne.	μ	Elementary/Secondary (0-12)	College (1-4or 5	i+) V			of Oper	attana	Stru	ctural	
N	Hygie Hygie other		12 17. Father's Name (First, Middle, Last)		100 1	Lesident	18. Mother's Nar		Maiden Si	Engine	ering
ב	ould be f Mental I Marked of latic eve	Be	Lewis Hoover	,					yn Nic		•	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or items 23a or 28a-1 show eumatic event, the Medical Examiner must be notified at	ဥ	19a. Informant's Name/Relationship (Tuno Print		Oh Mailie	a Addrass (Street	and Number or Ru				in Codal
<u>a</u>	d 2 sl h an 7 le r treur				110		S 100					
	1 and Healt em 2 ther		Shelley B. Hoo	ver / Wife	20b. Place	13815 of Dispo	Liberty sition (Name of	Mill Ro	ad, Geri	20c Loca	m, Mi	20874
ઠ્	T S T S T		1 ☐ Burial 2 X Cremation 3 C		Metro	etery, cren ODOLI	natory or other pla Ltan	Apri	1 3			
altimore,	rtmer rtant rtant		4 Donation 5 Other (Special			Cre	ematory	† 20	06 Dovol Fr		_	Virginia 10 East
g	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: If Item 27 Ie marked eny injury or other treumatic evonce.		21. Signature of Funeral Service Lice	11111		22	Name and Address Deer Par	k Drive,				
			23a. Part1. Enter the disease, or com	plications that caused	the death. D	o not ent	er the mode of dy	ng, such as cardiac	or respiratory a	ırrest,		Approximate fnterval Between
	Physician		shock, or heart failure. List only immediate Cause (Final	one cause on each in	1 1	mig						Onset and Death
E.	/Medical		disease or condition resulting in death)	aDue to (or as	1 / 1							minutes
	Examiner											
		er	Sequentially list conditions, if any, leading to immediate	Due to for as	a cons queno	ce of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
ó	exectan and rial-tr	EX	resulting in death) Last	Due to (or as	a consequenc	ce of):						
58760,	ficate be executed physician and is the burial-transit	edical		d								
_	tifica ng ph as th		IF FEMALE:									
ŏ	death certific attending pl	An/	23b. Was decedent pregnant	23c. ff yes, outcome 1 ☐ Live birth			Ectopic pregnanc	v		230	d. Date of deliv	*
P.O. Box	The law requires that the death certif ste has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐ Unknown			Other (specify)				Month	Day Year
<u>.</u>	res that the de signed by the a l be detached f	h	9 🗆 Unknown									
_	gned be de	Ď	Part II. Other significant conditions	contributing to death be	ut not resultin	g in the ur	nderlying cause give	ven in Part f.				the cause of death?
Š	w require been sij should b	E G							1 🗆	Yes 2∐1	No 3 □ Pro	bably 4 Unknown
ပ္ထ	lawr as be 2 sh	Completed							24a. Was	an 2	24b. Were aut	opsy findings available ompletion of cause of
Ĭ	The ete h page	mo.								ormed?	death? 1 ☐ Yes	2□ No
<u>=</u>	ien: artifica	Bec	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	<i>f</i>		
>	ding Physicien: The lav h. After this certificete has funeral director, page 2	To	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	nt 2 ER/	Outpatien	t 3 DOA Ot	ner: 4 🗌 Nursing H	Iome 5 Resi	dence 6	Other (Speci	fy)
Division of Vital Records,	ng Pt		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injui	ry 28t	b. Time of Injury	28c. Inju Wo	ry at	28d. Describe	how injury o	occurred	
<u>Ö</u>	endir seth. or; Al	atle	2 ☐ Accident investigation	n		,,		Yes 2 □No				
<u>Š</u>	or Attending Physicien: Ifter deeth. Director; After this certifice in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, c. (Specify)	, farm, str	eet, factory, office		28f. Location (City or To		Vumber or Rur	al Route Number,
	ital o	Ce										
	To the Hospital or Attent within 24 hours after deet for the Funeral Director; completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Pl 2 Medical Example	nysician: To the best on miner: On the basis of and manner sta	examination	dge, death and/or inv	occurred at the ti vestigation, in my	me, date and place opinion, death occu	e, and due to the tred at the time,	cause(s) an date and pl	nd manner as s ace, and due t	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)
	⊢s⊢ŏ) Ran (you N	L.DI		D	59729			127/2	
	13		30. Name and address of person who			a) (Type		7			1	-
	12		Min - 22-70		0 - 1			Poolered 1	1.0 1/10	20050		
	Sta	te	Aaron Snyder M.D 31. Date filed (Manus Pay, Year)	32 Registra	ar's Signature			, MUCKVII	TE, MID	<u> </u>	-	
	Registr		APK 042	2006	a St.	60	ede					